International Youth Year page 7

Calendar for 1985 The centre section

Solvent abuse: One Canadian city struggles with the problem The Back Page

Vol. 14, No 1 2nd Class Mail Reg No. 2776 TORONTO January 1, 1985

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Use is spreading outward, says RCMP

Canadian cocaine statistics are all 'way up'

By Anne MacLennan

OTTAWA — Law enforcement figures on cocaine are "almost doubling as we go along," says the chief of drug enforcement for the Royal Canadian Mounted Police (RCMP).

"All the statistics on cocaine are up significantly," Superintendent Rodney T. Stamler, officer-in-charge, headquarters, told **The Journal**.

"Use is higher here now than it has ever been before," and intelligence at street level indicates "more and more people are requiring treatment to quit the habit."

As well, he said, use is spreading outward through society. "In 1980-81, it was mainly used by middle- and upper-income people, unlike heroin, which was used by addicts, and marijuana, which was used by young people and high school students.

"Now, we see cocaine being used as well by students, by some heroin addicts who use coke to give them the extra lift, and by lower-income groups.

"We have almost a doubling of use if we look at the cocaine seizures, and that trend is certainly holding fairly strong."

Supt Stamler was commenting on the latest National Drug Intelligence Estimate, a now-annual report from the RCMP on drug trends (**The Journal**, Jan, 1984, Feb, 1983). The report for 1983, the year for which the most recent final figures are available, was released here in December by solicitor-general Elmer MacKay.

The RCMP bases estimates of both drug imports to Canada, and extent of drug use, on intelligence reports and seizures of drugs from the illicit traffic, as well as other indicators.

In 1983, the report shows cocaine seizures more than doubled to 98 kilograms from 46 kg in 1982.

The figures cover RCMP seizures only, and only in Canada. "There have been significant seizures" (of cocaine destined for Canada) made outside Canada by the RCMP in association with other enforcement agencies. "But these figures are for seizures in Canada," said Supt Stamler.

And unlike heroin, which is sometimes seized here in transit to the United States, cocaine entering Canada is for domestic consumption.

"We're at the northern end of the line. All the cocaine that enters Canada is generally for the Canadian market," he said.

Although the final report for 1984 won't be available until late this year, Supt Stamler said: "We can now see into 1984 that the trend continued and is holding fairly strongly."

Meanwhile, heroin is also on the increase, he said. "We've always had a fair bit on the street in Vancouver. But we are seeing significant quantities being sold at street level now in Toronto and Montreal and even places like Ottawa."

He said it's encouraging, however, that the purity level of street heroin has not changed greatly in Canada.

"It's very low — from 3% to 5% — and that's been constant through the years. And even with increased quantities coming in, there hasn't been much of a change in that."

In comparison, purity of street level heroin in Europe is sometimes as high as 40%, he said.

Next month:
More from the National Drug Intelligence Estimate

Alberta tries 'friendly force' tack

By Terri Etherington

TORONTO — Getting a message out to an intended target group is no easy task.

For the Alberta Alcoholism and Drug Abuse Commission (AADAC) a program aimed at teaching young people responsible attitudes toward alcohol (see page 2) began with a change in the whole image of the commission.

An initial campaign was run to position the AADAC as an "innovative, comprehensive addictions education and treatment agency. And, most specifically, as a friendly force to adolescents," says the AADAC executive director Jan Skirrow.

"Programs of social change require an objective assessment of the factors in the sponsoring agency likely to contribute to success or failure," Mr Skirrow said.

Prior to launching its mass-media campaign, the AADAC launched an internal "marketing" strategy to prepare staff and decision makers "for what would be seen as a radical departure from previous approaches."

Then it went to the public.

The AADAC told Albertans: "We're looking at old problems in new ways."

A new logo was designed, and all AADAC brochures, print materials, and program guides were redesigned and, in some cases, rewritten so they would be acceptable and understandable by the young target group.

It seems to be working.

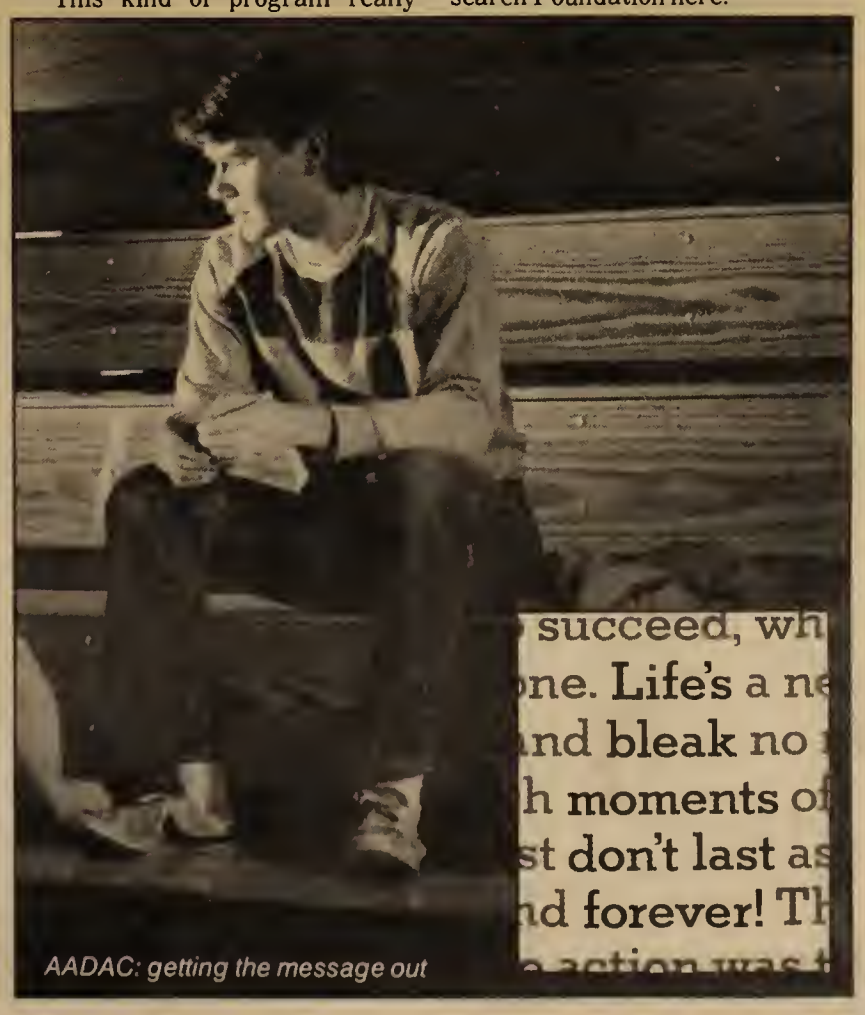
"It would have been difficult to find an adolescent in the province who knew of our existence three-and-a-half years ago. It's now difficult to find one who doesn't. And overwhelmingly they view us positively," says Mr Skirrow.

But, the success of the campaign has gone beyond just reaching teenagers. Since the program started, Mr Skirrow said, there has been a 40% to 50% increase in the treatment load, "with no change in the resource level."

A recent Gallup survey confirmed more people know about the commission and more people are using its services.

Between 1984 and a pre-program survey in 1980, the number of people who had had contact with the AADAC increased to 14% from 9% — that's 90,000 Albertans, or at least 22,000 new people each year.

"This kind of program really does bring people out to services," Mr Skirrow told addiction workers at a lecture at the Addiction Research Foundation here.



AADAC: getting the message out

FDA approves naltrexone for addicts

WASHINGTON — Formal approval has been given by the United States Food and Drug Administration for the commercial marketing of naltrexone in treatment of heroin addicts.

The agency said naltrexone is intended for use by people who are off heroin and in treatment. It should not be used for those still or heroin.

Margaret Heckler, secretary of the US department of health and human services, said naltrexone "provides us with a new weapon in the war against addiction by strengthening and extending the recovering addict's will-power."

Tougher DWI law will do little

By Terri Etherington

TORONTO — Proposed tougher laws and penalties for drinking and driving will do little to reduce the toll of death and injury on the highways, says a Canadian legal scholar.

"There is a difference between change and progress," says Robert Solomon, law professor at the University of Western Ontario. "While the new federal law may give the appearance of concern about the alcohol problem, I have serious doubts about the overall impact."

Mr Solomon told a drinking and driving symposium here in November that changes, which were scheduled to be introduced before Christmas by Justice Minister John Crosbie, will have a marginal impact, if any, and are "politically-oriented, as opposed to being oriented for the purpose of actually accomplishing anything."

Legislative proposals include increased penalties for impaired driving, provision for taking blood samples from drivers unable to provide breath samples, two new criminal charges — for impaired driving causing death, and impaired driving causing bodily injury — and federal law to impound the cars of convicted drunk drivers.

Minimum penalties for impaired driving are to increase to $300 from $50 with maximum fines, up to

(See — Attitudes — page 2)

INSIDE

NEWS

Briefly ...

A pressing problem

LONDON — Things are looking bleak in Worchestershire. Regulars at a pub called The Plough are worried that their favorite scrumpy (fermented apple cider) may soon be a thing of the past. Pub owner and scrumpy producer Fred Webber told *The London Sunday Times* that his brew is so popular it's attracted "loutish" outsiders by the busload. He's tired of breaking up fights and removing comatose youths from his premises and, if his plan to stay open on weekdays only doesn't solve the problem, he'll give up pressing apples forever.

Coke squad grounded

LIMA — United States diplomats are worried that Peru has given up the will to carry on the anti-cocaine battle. Following the massacre, last November, of 21 members of the anti-cocaine squad here, remaining members have been transferred to the country's police aviation division. But, reports *The London Sunday Times*, the aviation squad's only flying equipment is an old wooden propeller fixed to the headquarters' wall and a couple of single-engined aircraft long grounded for lack of spare parts.

Beer and the scales

HAYWARD, Cal — A new fad diet here may gain popularity with those who want to take off pounds but not give up their beer. The low-carbohydrate, high-protein diet is serious, says originator Martin Lipp, an emergency medicine physician. Dr Lipp says the "I Like My Beer Diet" is perfect for those who want to take off five to 15 pounds and "maintain all their bad habits intact." The 1,000 calories a day allows for 300 calories in two regular beers or three light beers, reports *The Toronto Star*.

Gifts for sober drivers

TORONTO — A plan to reward sober drivers, as well as punishing those less-than-sober, was put into practice here over the holiday period. Police at the annual Christmas spot checks were giving unimpaired drivers ice scrapers, garbage bags, and coasters. On the other hand, those who didn't pass the breath test received only arrest, detention, court appearance, licence suspension, fines, and possibly jail.

Kissing habit

LONDON —Those lovers locked in passionate embrace may look like they're kissing, but they are really just sampling each other's semiochemicals. Love, says Florida dermatologist Bubba Nicholson, is a chemical reaction, and kissing is the way we imbibe the drug. In an article in the *British Journal of Dermatology*, Dr Nicholson says the drug we seek is sebum, produced by the sebaceous glands which are located on the skin, primarily on the face, neck, scalp, and female nipples.

Kingston newspaper first in Canada to prohibit tobacco advertisements

By Angela Mangiacasale

KINGSTON — Congratulatory calls and letters have poured into his office since publisher Michael Davies announced his daily newspaper here would stop accepting tobacco advertising.

The decision was based on research which shows smoking is a serious health hazard. "*The Whig-Standard* will put its social conscience before its commercial interests," said Mr Davies.

Revenue loss as a result of the ban is estimated at $50,000 for 1985 for the independently-owned newspaper serving this city of 60,000.

"I think that smoking as a social habit, two or three decades from now, will involve a very small percentage of the population," Mr Davies said.

"It'll be a slow, grinding-down process," to eliminate the habit. "I'm just giving the ball a bit of a push."

The change in policy, Mr Davies said, will not mean that every tobacco ad will disappear from the newspaper.

"There may occasionally still be an ad for tobacco products in the newspaper, simply because we don't control the inserts — from drug store chains, for example — that we deliver but which are printed elsewhere.

"What I'm trying to do is stop these ads which equate smoking with a positive lifestyle. We're trying to be sensible about this. We're making a statement."

The ban has been applauded by Canadian Health Minister Jake Epp who commended Mr Davies for "putting his money where his mouth is."

Mr Epp: "In the larger context, it's a small step, but a very valid step. There is no question that the studies we've had, including the most recent ones . . . show that tobacco is the number one carcinogen that society comes in contact with."

Ontario Health Minister Keith Norton, who represents Kingston and the Islands in the provincial legislature, joined Mr Epp in calling on other newspapers to follow Kingston's lead.

Terry Luther, former United States surgeon-general — who first linked smoking to lung cancer and other diseases two decades ago — called *The Whig-Standard*'s decision one of "great significance." Dr Luther said it was "quite a step for your press (in Canada) to take."

While no other newspaper in Canada has banned tobacco ads, a handful of small newspapers in the US has imposed such bans for ethical and health reasons.

Support has also come from several health and education groups, and health publications.

Representatives of the tobacco industry, however, have called the ban "commercial censorship."

Norman McDonald, executive-director of the Canadian Tobacco Manufacturers' Council, said: "I find it very disturbing. This is a legitimate product. However, it's the publisher's decision."

NIDA chief wants limits on cigarette promotion

WASHINGTON — Society should find a way to limit the freedom to promote tobacco use, declares William Pollin, director of the United States National Institute on Drug Abuse.

Dr Pollin believes that when measured by morbidity and mortality, cigarette smoking is now the most serious, as well as the most widespread, addiction in the world. About 75% of those addicted to nicotine have tried and failed to cut down or quit smoking.

Dr Pollin, who made his outspoken observations in a recent article in *The Journal of the American Medical Association*, said the 350,000 deaths annually associated with cigarette smoking is seven times more than all automobile fatalities, or more than 100 times all recorded deaths from AIDS.

Tobacco addiction is far more resistant to treatment than heroin addiction, he said.

Dr Pollin agreed that any attempt to prohibit the use of tobacco will fail but "it does appear that our society should seek some appropriate way to inhibit the present degree of freedom to push its most prevalent drug of abuse — nicotine."

Public service announcements don't work

AADAC is reaching youth in prime time

By Terri Etherington

TORONTO — A youth anti-alcohol campaign with better audience penetration than McDonalds restaurants? That's what the Alberta Alcoholism and Drug Abuse Commission (AADAC) is claiming. And surveys of Alberta residents are backing up these claims.

The secret, the AADAC maintains, is buying prime time mass-media space and filling it with slick, high-powered messages for youth and those with most control over youth behavior — parents.

"Public service announcements just don't work," says Jan Skirrow, executive director of the AADAC. He outlined the youth awareness program at a lecture at the Addiction Research Foundation here recently.

Alberta's high-priced message (almost $3 million a year for the last three years) is working.

A survey at the end of the program's second year showed that 72% of adolescents, 53% of mothers, and 40% of fathers either mentioned the AADAC by name, or were aware of the AADAC commercials without prompting.

Asked if they had seen a commercial with a specific theme, 99% of teenagers, 70% of mothers, and 60% of fathers recognized at least one major theme.

Skirrow

"This degree of both aided and unaided awareness is very high for any mass-media-based communication program," said Mr Skirrow, "and is, in fact, in some respects, even a little bit higher than McDonalds achieves."

Teens and parents not only know about the program, they like it. More than 75% of mothers and 60% of fathers aware of the program thought it was an excellent idea. Teenagers were less enthusiastic, with only 50% considering the commercials an "excellent idea." However, Mr Skirrow said, more than 90% of teens thought it was at least a good idea.

And, the AADAC is getting its message across "without beating people over the head." Most of the commercials don't even mention alcohol.

"Rather, the program addresses some factors thought to be basic to adolescents' attempts to gain control of their lives and develop into healthy adults," Mr Skirrow said.

One of the most popular themes — Make the most of a good thing. Make the most of you — has "really taken off," said Mr Skirrow. Commercials based on this theme highlight the need for "responsible independence."

Mr Skirrow: "We're saying if you want to be a brain surgeon, you are not going to be able to drink three quarts a day. A lot of kids don't see any connection whatsoever between what they do now and what they want to be down the road. We are trying to introduce the notion that there is a connection between present behavior and future possibilities."

The commercials use "real people," not actors, to play out decision making, peer interaction, goal setting, parent-child communication, and responsibility. This makes the commercials more believable, Mr Skirrow says.

A new series of commercials is now being developed on the theme: Life's bleak moments don't last forever. They aim to forestall young people's use of alcohol as a way of dealing with stress.

Attitudes, not laws, need changing

(from page 1)

$2,000 remaining the same.

While Mr Solomon admitted all these provisions are a "step in the right direction," he argued none would "fundamentally change drinking and driving behavior in this country."

He said existing laws already provide heavy penalties. "So when they talk about brand new, squeaky clean, shiny new federal drinking and driving laws, I'm always inclined to say, what about the scads of drinking and driving laws we've got now?

"If the courts are not going to impose anywhere near the maximum penalties now, under the old law, why would anyone think they are going to impose the maximums under the new law?"

On blood testing of drivers incapable of providing breath samples, Mr Solomon commented: "There are 175,000 drinking and driving arrests a year in Canada. What are we going to do if we now have the power to demand blood samples? Are we going to get another 300, another 400? What is the difference?"

Solomon

Police officers can already arrest those drivers, he said. "The officer can detect the smell of alcohol on the breath even if the driver is unconscious, and he can subpoena the hospital record."

Many provinces already have automatic, short-term, licence suspensions; it's unlikely a federal law will make a difference, he said.

"If a driver is not concerned about killing himself and killing somebody else, if he is not concerned about being charged criminally, if he is not concerned about civil liability, if he is not concerned about his insurance rates doubling automatically, do you think he is going to be stopped because there is now a federal offence to take away his licence?"

Creation of new offences for people who drive while impaired and cause death or injury will make a difference only if the attitude of the courts changes, Mr Solomon said. "As long as the courts and the crown attorneys and the public generally don't consider drinking and driving to be particularly serious," these new offences will have little impact.

As criminal sanctions in the past have done little to reduce the problem, Mr Solomon suggests measures to control drinking behavior, such as price increases and reduced availability, should be attempted.

For now, however, "If I was a politician, and I was facing an electorate that wanted me to talk out of both sides of my mouth at the same time, I would say: 'I am going to crack down on drinking and driving, but I am going to do so in a way that doesn't interfere with my revenue. I am going to support broad criminal sanctions against drinking drivers, but I am not going to take steps to attempt to restrict the availability of alcohol.'"

NEWS

Built-in warning system deters drinking drivers

Car lights, horn tell driver he's had too much

By Brian McCann

DENVER — A built-in warning system that flashes car lights and honks the horn if the driver has had too much to drink has passed a stiff test.

In a group of 17 convicted driving-while-impaired (DWI) offenders, the Drunk Driving Warning System (DDWS) kept drinkers off the road, says Anthony Stein, staff psychologist at the California-based Systems Technology, Inc, which developed the system.

He said the test was conducted during a period of six months, with the blessing of the court, which allowed the DWI offenders to drive only with cars equipped with the warning system.

Dr Stein told the annual meeting of the American Association for Automotive Medicine here that if the driver fails a steering competency test — the Critical Tracking Test — built into the DDWS system, an emergency flasher system is activated and the horn will sound once per minute if the car is driven more than 10 mph.

If the driver fails the critical tracking task, he or she must wait 10 minutes before trying again. Various interlocks and other design features are included to deter the driver from bypassing the test and the DDWS, Dr Stein added.

The purpose of the DDWS study was to evaluate its feasibility, both in detecting alcohol impairment and as a judicial sanction in a probationary setting, he said.

"We wanted to know whether it could work within the system. If you can't find a judge who is willing to use this as a sentencing tool, it has no feasibility. If the defendants refuse to drive a car equipped with this system, it's not feasible.

"Each subject was assigned a vehicle, the vehicle had the system in it, and the driver's licence was restricted to driving that vehicle only," he said. "That was their only means of transportation for six months."

Under California law, people convicted of impaired driving must complete a one-year program for problem drinkers or lose their licence. A temporary state law was passed to allow judges to have the option of assigning the subjects to the DDWS program only, said Dr Stein.

"The judges felt it was a very good alternative for many of their defendants.

"These people were showing up, and the judges knew that pulling their licences was a detriment to society. These are people who held jobs, who were basically socially responsible, carried insurance, and wouldn't think of driving without a licence," he added.

"The problem was they didn't know when to stop drinking or when not to get in the car. This particular group of drivers — I won't say all drunk drivers — really don't want to drink and drive," Dr Stein said.

'Jerky eye' test shows up impaired drivers

DENVER — A speedy gaze nystagmus, or "jerky eye" test, can detect if a motorist is intoxicated.

In a report to the annual meeting here of the American Association for Automotive Medicine, Monroe Snyder, PhD, said that "now, in less than a minute, an officer will be able to pass the vast majority of sober drivers, but few if any of the drivers over the 0.10% blood alcohol limit."

The test involves having the motorist look to one side. The more distinctly his eyes jerk back and forth (gaze nystagmus), the more that individual is found to have a high blood alcohol level.

Dr Snyder, chief of problem behaviors research division, United States National Highway Traffic Safety Administration, Washington, said police officers using the test correctly identified all individuals in an experimental setting who had a blood alcohol level of 0.10% or higher. With individuals at a 0.05% blood alcohol level, he said, there was a false positive rate of about 13%.

"The results are striking and of great practical significance," said Dr Snyder. "Most court opinions, as well as practical political wisdom, indicate that safety checkpoints should not cause significant interference with the travel of citizens whose blood limits of alcohol are not too high. Now this can be done in less than a minute."

As for the few drivers who are not passed, he said, "they could be given the opportunity to take a quick test with a portable breath-tester."

Local hotline filling a gap

BC athletes getting drug advice

By Tim Padmore

VANCOUVER — A telephone hotline on drugs and sport, started here last October, is finding that local athletes, including high schoolers and body-builders, want advice on drugs.

The hotline, operated by the Sports Medicine Council of British Columbia in cooperation with the University of BC's (UBC) sports medicine clinic, offers advice on the use of anabolic steroids, growth hormones, amphetamines, and other stimulants. Use of these putative, performance-enhancing drugs is opposed by the Council.

Doug Clement, MD, co-director of the clinic and a member of the national committee on doping control of the Sports Medicine Council of Canada, told **The Journal** the hotline is a first step to filling a serious gap in the information available to athletes.

At the national level, athletes face strict policing and a determined educational effort.

"For the community-based athlete," said Dr Clement, "there isn't the same opportunity."

In the first three days of operation, the hotline had about 25 calls, almost all of them inquiring about the use of anabolic steroids.

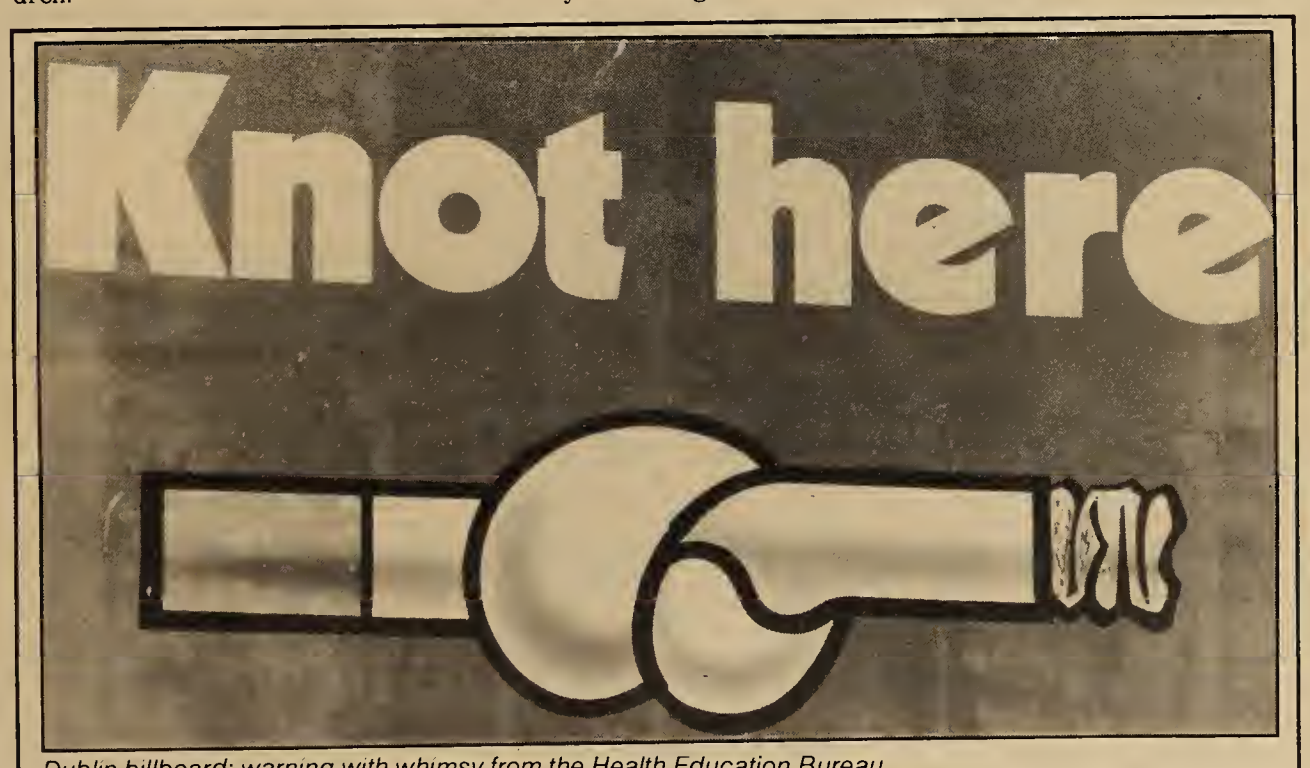
These drugs, which are available by prescription from some doctors, from underground sources, and even from mail order houses, are used to build muscle mass and strength. Risks include acne, high blood pressure, heart disease, testicular and liver damage, impotence, and cancer — not to mention the possibility there will be no gain in athletic performance.

Dr Clement said the calls are coming both from users and from those contemplating use of the drugs, including parents who want to give the steroids to their children.

Jack Taunton, MD, chairman of the Council in BC and co-director with Dr Clement of the UBC clinic, said more and more high school football players are using steroids, and recreational body-builders, both male and female, use the drugs.

"We want them to be informed of the consequences — that you'd be a fool to take drugs."

Operating the hotline telephone (604-228-3049) is Council executive director Lynda Filsinger.



Dublin billboard: warning with whimsy from the Health Education Bureau

I will be calm, graceful, serene, diligent . . .

By Wayne Howell

The universe really does unfold as it should. That is the message that we should take into a New Year. We all should strive to set personal prejudice and petty concerns aside, and accept the inevitable with grace and understanding. Serenity and equanimity should be our goal; it is the key to a long and happy life. We should rigorously root out the kind of "type A" thoughts and behavior the experts tell us can only lead to mental turbulence, physical hyperactivity, and the Intensive Care Unit of the cardiac ward. And so, in this regard, I make the following New Year's Resolutions:

1. I will no longer concern myself with idle speculation as to the outcome of the case of the New Brunswicker who was fined $200 for having "marijuana breath," had he had access to the kinds of lawyers defending New Brunswick Premier Richard Hatfield on his marijuana rap. Such speculation is born in umbrageousness, lives in cynicism, and is definitely unworthy of me.

2. I will never again wax righteous and indignant about alcohol and other drug programs that are "targetted" rather than "aimed" at certain groups. I will graciously accede to the wisdom of the venerable CBC (Canadian Broadcasting Corporation) and the esteemed newspaper *The Globe and Mail* which find this usage as acceptable as "hostage dramas" in the case of hostage-taking incidents.

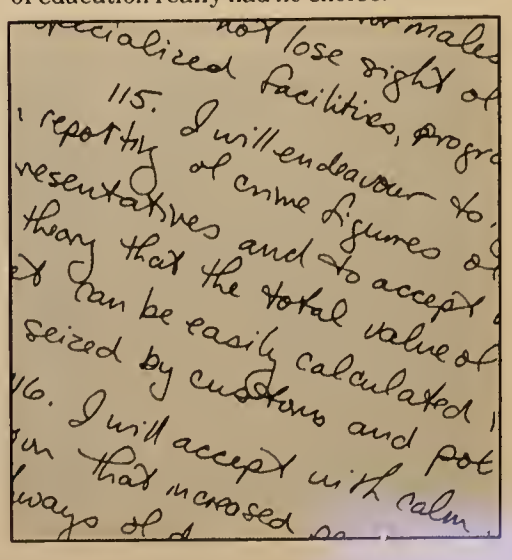
3. I will suppress with diligence unworthy thoughts about the current campaign to legalize heroin in Canada. To be specific, I will suppress the following notions:
a) That the analgesic efficacy of heroin, like the anti-neoplastic activity of peach-pits, is directly proportional to the degrec to which it is disparaged by domestic experts, and the distance in miles a person has to travel to avail himself to it.
b) That people who advocate its use know that, and prey on the paranoid fantasies of those who feel (and need to feel) that there is something wonderful out there that "thc authorities" prevent them from getting just out of spite.
c) That the "legalize heroin" issue is a natural motherhood issue around which politicians of all stripes rally without thought, because it is without fear of backlash. (Heroin for suffering grand-moms is one thing; abortion for young moms is quite another.)
d) That notwithstanding a), b), and c), the 1984 "Report of the Expert Advisory Committee on the Management of Severe Chronic Pain in Cancer Patients" to the Minister of Health and Welfare, recently excerpted and distributed to all doctors as "A Monograph on the Management of Cancer Pain," is excessively slick and devious: in 40 pages of double-column text it manages to discuss heroin, the drug that caused the brouhaha that caused the report to be commissioned in the first place, in precisely 11 lines.

4. I will no longer be bugged by the fact that the Ontario Association of Policc Chiefs and the Ontario ministry of education chose Mr T as the super-hero to deliver their anti-drug mcssage to Ontario nine to 11 year olds rather than Wayne Gretzky. I will put "nationalistic" prejudice asidc and look at the facts calmly and dispassionatcly.

The facts about Waync Gretzky are that:
a) He was born in the Ontario hcartland.
b) Hc is an ordinary-looking person who does extraordinary things playing Canada's national sport.
c) He is a gentleman player in a sometimes brutal game.
d) He looks like the kind of boy you would let your teenage daughter go out with.

The facts about Mr T are that:
a) He was born in the United States.
b) He is an extraordinary-looking person who does ordinary things (bashing pcople about) on US network television.
c) He has a mean-looking, punk haircut.
d) He drcsses like a prospcrous pimp.

When onc looks at thc situation this way — calmly and dispassionately — one can see that the policc chiefs and thc ministry of education really had no choice.



NEWS

RESEARCH UPDATE

Abstainers a diverse group

Alcohol researchers would be wise not to treat abstainers as a homogeneous group, a pair of researchers has suggested. As part of a study of drinking practices, 5,320 adults in the Boston, England, area were interviewed, of whom 15% had not consumed alcohol in the past year. Further investigation by Eli Goldman, PhD, and Jackob Najman, PhD, found three clear groups of abstainers could be identified in this sample. Of the abstainers, 58% were lifetime abstainers, 34% were current abstainers without a drinking problem, and 9% reported they had once had a drinking problem. This latter group, the study said, had socio-demographic characteristics similar to moderate or frequent drinkers. The dangers of treating abstainers as a united group, as many researchers have done, is to mix people who have a past history of heavy drinking with those who drank lightly or never, the researchers concluded. This invites methodological problems when conclusions are drawn from these studies.

British Journal of Addiction, Oct 1984, v.79:309-314

Depression hinders opiate detoxification

Degree of depression can prove an important predictor of the success of detoxification in opiate addicts. That is the conclusion reached by three Connecticut researchers who assessed depressive symptoms in a group of 44 ex-addicts assigned to a one-month detoxification program involving either the slow tapering of methadone or the use of clonidine. Depressive symptoms were assessed at the start of the program and throughout the detoxification period. It was found that the 18 ex-addicts who were successfully detoxified from a 20 milligram daily dose of methadone had significantly lower depression scores before the start of the detoxification than the 26 who were not successful. There was no significant difference between the clonidine-treated group and the group in which methadone was slowly tapered. The course of depressive symptoms was also predictive of detoxification failure, with ex-addicts who remained depressed, or developed more depressive symptoms during the 30-day detoxification, being more likely to fail. The researchers from the psychiatry department, Yale University School of Medicine, and the drug dependence unit, Connecticut Mental Health Center, suggest successful detoxification of moderately-depressed ex-addicts could be aided by hospitalization and use of clonidine to complete detoxification relatively rapidly or to delay final phases of detoxification until the patient is no longer depressed.

Comprehensive Psychiatry, Sept/Oct 1984, v.25:503-508

Caffeine dietary preference in children

Children may self-select dietary caffeine in a systematic way, suggests a study which compared high caffeine consumers to low caffeine consumers. From a survey of 24-hour caffeine intake of almost 800 grade-school children, 19 children who reported consuming more than 500 milligrams per day of caffeine were matched with 19 children whose reported intake of caffeine was 50 mg per day or less. In a double-blind, placebo-controlled study, these two groups of children received, 5 mg/kilogram caffeine or placebo for two weeks each. The researchers from the United States National Institute of Mental Health, Bethesda, Md, and the department of pharmacology, University of Florida School of Medicine, Gainesville, found that when they were not receiving caffeine, the reported high consumers had higher scores on an anxiety questionnaire and tended to have lower autonomic arousal as measured by skin response. While receiving caffeine, this group was not noted to have changed from normal by their parents. However, the low-consuming group was perceived as being more emotional, inattentive, and restless after caffeine consumption. The researchers said this difference in response could not be attributed to withdrawal or tolerance effects of the caffeine. Dietary history, the study concluded, predicted behavioral response to caffeine with these children. The study said such a developmental response to dietary choice "may provide an important bridge between behavioral dietary toxic effects and underlying individual physiological differences that lead to selective food intake."

Annals of General Psychiatry, Nov 1984, v.41:1073-1079

Maternal drinking tied to low birth weight

A large, prospective study has shown a direct relationship between the amount of alcohol consumed during pregnancy and infant birth weights. Information on maternal drinking in the first trimester was gathered on 31,604 women by the Kaiser-Permanente medical company of Northern California. Researchers from the United States National Institute of Child Health and Human Development, and the US National Institutes of Health, Bethesda, Md, found that the proportion of newborns weighing less than 2,500 grams increased consistently with the mothers' increasing alcohol consumption. The percentage of newborns falling below the 10th percentile of weight for race, sex, and gestational age ranged from 5.8% in the group of non-drinking women and 6.9% in those who had less than one drink per day, to 17.7% in the group of women who reported having more than six drinks a day. This relationship remained true even when the effect of maternal smoking was taken into account. The study concluded that "the woman who consumes at least one to two drinks each day is substantially increasing her chances of producing a growth-retarded infant." Conversely, the study suggests, "an occasional drink has only a trivial effect on interuterine growth."

Journal of the American Medical Association, Oct 12, 1984, v.252:1875-1879

Pat Rich

Drinking drivers and youth top Manitoba's priority list

By Maureen Brosnahan

WINNIPEG — Although money is tight and threats of government cutbacks loom continually, the Alcoholism Foundation of Manitoba (AFM) is determined to plough ahead and plan new and expand existing programs, says its executive director.

Ross Ramsey said he does not expect a large increase in the organization's $10 million budget next year, most of which comes from the provincial government. But, he said he's confident the foundation can hold the line on costs.

"I have to be somewhat optimistic," he told **The Journal**.

With the province's continued focus on impaired driving, Mr Ramsey said programs to educate people about drinking and driving will likely be expanded.

He pointed to the province's move last year to bring in mandatory education programs for those first offenders charged with impaired driving and the expansion of the AFM's mandatory program for second offenders.

Mr Ramsey said he would like to see the AFM expand its programs for young people with chemical dependency problems. At present, the foundation offers a day treatment program in some areas of the province, but there is no residential program.

Ramsey: optimistic

Youth services are limited in many areas of the province, which is frustrating for those who identify children who need help but for whom it's not available, he said. "They're coming to the point where they need our help, but we can't help them," he said.

"We're doing as much as we can but we're not very proud of what we're able to do."

He said the case loads of young people, especially those between 15 and 18 years, have risen 30% in each of the last three years. Last year, the number of young people seen rose to 650 from 522.

Mr Ramsey said the jump is not so much an increase in the problem as an awareness of the AFM. "I think it's people getting to know us more."

Mr Ramsey said his long-term goal would be to establish a residential treatment program for young people. But, in the short-term, he wants to ensure the same level of non-residence programs for all young people in the province.

In the same vein, he said, the AFM is continuing to work with provincial officials to develop an alcohol and other drug education program for junior high school students. This would add another component to the Tuning In To Health program (**The Journal**, Sept, 1984) which was introduced in elementary schools last fall.

In adult programs, Mr Ramsey said the AFM would like to expand services into new areas of the province, especially the southeast and southwest regions, where there are few programs to help.

Now, he said, many who need help must travel more than 100 miles to Winnipeg for treatment. But the real problem, he said, is that there is little follow-up or contact with these people when they return home.

Grassroots network of volunteers

CAF recruiting local chapters

By Terri Etherington

TORONTO — The Canadian Addictions Foundation (CAF) wants to strengthen its direct community involvement and to offer citizen groups a national volunteer framework through the formation of local, community chapters.

Acting on its pledge to seek more grassroots support (**The Journal**, June, 1984), the CAF has begun recruiting citizens interested in alcohol and other drug issues both nationally and locally.

Henry J. Schankula, chairman of the publicity and public relations committee of the CAF and provincial director for Ontario, told **The Journal** the move to establish chapters is a "perpetuation of the volunteer movement which seems to be growing in Canada. It's an idea whose time has come."

Mr Schankula, director of education resources for Ontario's Addiction Research Foundation here, said affiliation with the CAF would appeal to groups or individuals in a community "who perhaps aren't as single-purposed as some of the existing national groups." Interests of the CAF cover a range of alcohol and other drug misuse problems, from drinking and driving among young people, through heroin and other drug use, to control of alcoholic beverage advertising.

"The CAF is basically made up of people from responsible agencies and commissions in the provinces and represents a solid, reasonable, and probably conservative, scientific approach to the field," Mr Schankula said. "So affiliation does not involve risk of development of radical views."

Affiliation will also provide local volunteers with an opportunity to express their collective views and to have a national voice in the addictions field.

As few as three people may form a local chapter, Mr Schankula said, adding that individuals are also welcome to become CAF members.

"An advantage of local groups is that they can take a position based on emotion and can interact at a high advocacy level with politicians" — options that are not always open to regional offices of provincial commissions and foundations, Mr Schankula said.

The CAF offers organizational and resource support to chapters and provides a liaison and communication link among individuals and organizations at the volunteer level who have similar, local community interests and action plans.

Schankula

For information on individual membership or establishment of a local chapter, contact: The Canadian Addictions Foundation, Box 702, Pacific Plaza, 10909 Jasper Avenue, Edmonton, Alberta T5J 3M9, tel: (403) 421-0435.

Racial segregation limits drug treatment success

WASHINGTON — Substance abuse treatment programs designed by and for blacks only have been a tragedy, says Watson Haynes, chairman of the board of the Florida-based Operation PAR (Parental Awareness and Responsibility).

"There are no more segregated fountains in America, and we do not need any more segregated programs," he told the annual conference here of the National Federation of Parents for Drug-Free Youth.

Most blacks cannot afford a 28-day, private, in-patient treatment program, and it is humiliating for many who have to attend programs which are set in the heart of the black community, thus making it obvious they are seeking help.

Mr Haynes said the minority communities are more often the victims of drug trafficking than the perpetrators. "We don't own the boats and the planes that bring drugs into this country. I don't know many minority pilots or ship owners."

Nevertheless, he added, drugs are prevalent in minority communities, "and the society we live in incarcerates us as opposed to rehabilitating us. We look at white America and say they talk to the judge while we talk to the public defender."

Commenting on the United States National Institute on Drug Abuse campaign to get young people to "just say no," Mr Watson countered:

"How can you say no when there is no food in the pantry; how can you say no when there are no jobs; how can you say no when your family rejects you; how can you say no when the rent can't be paid; how can you say no when the only hope you have is a needle and a joint; how can you say no when there is a bar on every corner; how can you say no when every government agency that you seek help from either can't identify your problems, or after they do identify your problems, they say 'I can't help you'?"

Values, influences, and peers

Plan helps kids who can't say no

By Terri Etherington

TORONTO — Children with the lowest self-esteem are the most easily misled and need guidance to resist peer pressure to use drugs and engage in other anti-social behavior.

That is why a new program, Values, Influences and Peers (VIP) aims at helping grade 6 students develop reasoning skills, build self-esteem, and recognize peer pressure tactics.

VIP was developed jointly by Ontario's ministry of education and the ministry of the solicitor-general, and is designed to be team-taught by classroom teachers and community police officers.

Young people need to know how to cope and how to "say no to friends or peers and not feel they have lost anything," Jack Davis, education officer with the ministry of education, told the Drug Abuse and Youth conference here.

He said grade 6 was chosen as the appropriate time to introduce VIP because "grade 7 is a stepping-off point for many students." Many move to new, larger schools at this time, are "mixed in with a lot of new people," and can be faced with new pressures.

He told **The Journal** there is a need to provide such peer awareness programs "because of the prevalence of vandalism, involvement with drugs, and stealing." Vandalism, he said, is the prime problem. Toronto schools will face a $3 million repair bill this year as a result of damage to schools.

"We think the way to tackle this is to provide kids with peer pressure coping techniques . . . . Children need to be aware of the possibility of peer pressure so that they can recognize it when it is happening to them.

"The kid who can't say no is the kid whose self-esteem is low and who will do almost anything to get approval."

The VIP program features 13 topics: values and standards, creating impressions, belittling other people, peer pressure, role playing, decision making, authority and authority figures, being truthful, dangers of drugs, vandalism and destructive behavior, shoplifting is stealing, youth and the law, friends and friendships.

The segment on dangers of drugs involves two or three sessions and includes a field trip to an emergency ward of a hospital where a treatment centre is located, or a classroom visit from a representative of the Addiction Research Foundation, a doctor, or nurse, as a follow-up to the curriculum material.

Developed during the past two years, VIP has been revised following testing in eight school boards in both rural and urban settings, Mr Davis added. Response in all test areas was positive.

The conference was sponsored by the Toronto-based Drug Education Coordinating Council.

International Youth Year

Growing international concern about youth, and recognition of the contribution young people can make in shaping and designing the future, prompted the United Nations to designate this year — 1985 — International Youth Year (IYY). Participation, development, and peace will be the themes.

The Journal will support these ideals by featuring a continuing exchange of information on youth — with special emphasis on research, education, treatment, and prevention of alcohol and other drug problems — and on world-wide efforts in this field to shape a better future for all.

Beginning with this page, as well as The Back Page article on solvent abuse in one Canadian city, The Journal will aid readers in spotting related articles by flagging them with the IYY logo (below).

The UN estimates close to 20% of the world's population — one in five — is in the 15- to 24-year age group. In 1991, the world youth population is expected to top the one billion mark. A majority of young people (665 million) live in the developing countries of Africa, Asia, and Latin America.

Golobitsh

Students do the teaching

Drug info needs real-life touch

By Terri Etherington

TORONTO — Drug education in all classes rather than classes in drug education is the tack an Ontario high school is taking.

At Markham District High School near here, information on drugs has been integrated into almost every core subject curriculum, says vice-principal Neil Galichan.

"Kids need to be able to deal with drug education wherever it comes up in real life and not have it isolated into some package," Mr Galichan told the Drug Abuse and Youth conference here. And, while they have not yet successfully integrated drug education into the math program, it is part of the course of study in English, science, history, and geography.

In 1979, the school and the community became concerned about drug use by students but found that teachers resisted the idea of taking on a drug education role. "They had a natural fear about teaching something they don't know anything about," Mr Galichan said.

Now, in science class, when talking about filtration, students discuss cigarettes — what the filter filters out, and what it leaves behind.

In English, an already-established unit is preparation of a newspaper article. Now, some students are being asked to write their article based on recently-released drug-use information from the Addiction Research Foundation here.

"In this way the information is coming at the students insidiously, not as drug education," said Mr Galichan.

"One of the things we learned along the way was that in the last 20 years there has been a change in the factors that influence young people in their decision-making process. Now the number-one influence is the peer group. This calls for a change in teaching strategies."

By integrating drug education into other curriculum areas, "we let the kids do the research and the presentation. It's students teaching students," he said.

Parents should avoid paranoia

By Maureen Brosnahan

WINNIPEG — Provincial governments could do more to curb deaths among young people by enforcing current drinking laws than by bickering about raising the drinking age, says a consultant to the Toronto-based Council on Drug Abuse.

Norman Panzica told the Current Issues in Chemical Dependency Conference here, that provinces should "stop screwing around" with the drinking age.

"I think we could make better use of the laws we have now," he said.

Instead, he suggested law enforcement officers patrol all drinking establishments on Friday nights and suspend the liquor licences of businesses found serving alcohol to minors.

He said the loss of revenue for hotels and other businesses — even if licences were revoked for only five days — would have a dramatic financial effect on them.

Mr Panzica told the conference that chemical dependency can occur among people from all walks of life.

He said parents should be aware of warning signs indicating their children may be involved with alcohol or other drugs but they should not become paranoid about it.

"Don't look at the eyes, look at the report cards, look at the bank books," he said.

Mr Panzica said there are many myths about drugs that need debunking. "I don't know of any field where more folks know more things that just ain't so," he said.

Mr Panzica said some statistics are now showing that drug education programs in schools are having an effect in that fewer young people are presenting for treatment. However, he said alcohol is still the main drug among young people.

Golobitsh

Alcohol: still the main drug among young people

University tackles campus drinking with information

LONDON, Ont — At a university party here, they ran out of light beer.

That's great, say organizers of a pilot project at the University of Western Ontario (UWO).

The project is aimed at teaching students ways to moderate their drinking. And while running out of beer may seem little reason for jubilation, representatives from the Addiction Research Foundation (ARF) and the university student services department believe it may be an early indication the project is working.

Students are being encouraged to "drink light" — if at all — by flyers in university pubs (above), lower prices for low-alcohol beer, and the stocking of only light draft beer in university pubs.

This point-of-purchase message, says Dave Hart, ARF community consultant here, is just one part of the program.

Last August 4,000 first-year students were mailed a brochure entitled, *Appropriactivity: An Undergraduate's Guide to Conviviality*. It stresses strategies to reduce the risk of drinking problems, with specific attention paid to four drinking behaviors: average alcohol consumption, drunkenness, drinking and driving, and drinking and studying.

"We're giving them the information they need," Mr Hart told **The Journal**. "It is up to them how they use it and what they decide to do with respect to their own drinking behavior."

Called Campus Alcohol Policies and Education (CAPE), the program includes posters, buttons, and booklets reinforcing the message to students to choose appropriate drinking behavior when they choose to drink.

The test of whether the program is working will come later. The ARF plans a follow-up survey of drinking habits of 1,500 UWO students in the spring. Results will be compared to those of a similar survey at the beginning of the year at the UWO, and a control survey of 1,500 students at another Ontario university.

Says Tom Seiss, director of student services at UWO: "Universities across Ontario and all over North America are recognizing that alcohol abuse is a much bigger problem than (other) drugs."

NEWS

RCMP publications gain international recognition

OTTAWA — The Drug Enforcement Branch of the Royal Canadian Mounted Police (RCMP) has received the 1984 professional service award for excellence in law enforcement publications.

In making the presentation, the International Association of Law Enforcement Intelligence Analysts (IALEIA) applauded the RCMP headquarters for "consistent, high-quality reporting of narcotics intelligence trends" which, the IALEIA said, "has strengthened international cooperation in the suppression of illicit drug traffic."

In particular, the *National Drug Intelligence Estimate* (**The Journal**, Jan, 1984, and page 1 this issue), "have made a monumental contribution to public understanding of the drug trafficking problem in Canada," the IALEIA citation noted.

A plaque and the citation were presented to Robert C. Fahlman, chief, Shelley A. Keele, senior intelligence analyst, and Hélène Vigeant, intelligence analyst, of the RCMP research and publications section.

The group was also awarded first prize in both 1983 and 1984 for the National Drug Intelligence Estimate by Canada's Information Services Institute, a voluntary professional association of federal government employees in communications professions.

Fahlman: award of excellence

NB drinking less beer and spirits but wine consumption soars 15%

By John Carroll

FREDERICTON — Gross revenues of the New Brunswick Liquor Corporation (NBLC) reached a new high in fiscal 1983-84, but the actual consumption of beer and spirits decreased, while wine-drinking gained in popularity.

In dollar terms, the market trend to beer and wine continued in the year ended March 31, 1984. But, in litres consumed, beer decreased nearly 2.5% to 51,563,382 from 52,863,300 litres. Spirits fell by a significant 9.8% to 3,700,762 litres from 4,103,973 litres.

If brewers and distillers are hurting, vintners should be happy. Wine consumption increased by more than 15% to 3,064,704 litres — up from 3,012,332.

While some consumption of alcohol has eased in this province, the cost of buying has climbed sharply. Higher federal and provincial taxes and increased NBLC markups ordered by the NB government pushed gross sales to a record $183,161,630. But, the level of consumer resistance is to be found in the fact that this was 2.5% less than the $187.8 million the NBLC anticipated.

While the gross revenue increased by 5.7%, the NBLC net income of $64,610,691 was 11.1% ahead of fiscal 1983.

The alcohol dollar was divided into 54.7% spent on beer, 35.9% on spirits, and 9.4% on wine. On a per capita basis, each of 715,000 New Brunswickers spent $256.17 on alcohol.

Driving under the influence in Scandinavia

Treatment/rehab go hand-in-hand with punishment

STOCKHOLM — Many believe that the Scandinavians are years ahead of other countries in dealing with social drinkers who drive while under the influence of alcohol.

Some aspects of the Scandinavian system, and current research elsewhere, were outlined by experts from Scandinavia, West Germany, and the United States at a recent international workshop here on punishment and treatment for drivers under the influence of alcohol and other drugs. It was held by the International Committee on Alcohol, Drugs and Traffic Safety and supported by the Karolinska Institute and the Swedish Society of Medical Sciences.

At the same time, Sweden's minority Social Democrat government is considering changes in the drunk-driving laws, although many believe there is small chance parliament will approve them.

Milan Valverius, MD, professor and direetor of the Swedish State Institute of Forensic Medicine here and head of the international committee, said the basic question is not one of punishment or treatment for the drunk driver. Punishment is viewed as necessary in society and a means to try to prevent crimes sueh as drunk driving. The only real issue is coordination of punishment with treatment/rehabilitation.

There is a major debate in Sweden about government proposals to change the present laws on drunk driving, which would, in effeet, reduee the number of people sent to jail for a first offence. "If you break the law on drunk driving, you must be punished. That is not the debate," Dr Valverius added.

He said a large-scale study he did some time ago in northern Sweden showed that at 10 pm on any night in Sweden, exeept Friday, an estimated 75% of the drivers are men. On Friday nights, however, nearly 70% of the drivers are women.

"Men drivers know the police are out and that it is highly risky to drink and drive. And the real fear drivers have is of losing their licence to drive — this is much greater than the fear of fines or of going to prison," he added.

In many cases, a licence will be revoked for at least two years. But there is no automatic restoration; those who lose their lieence for drunk driving must undergo examinations and driving tests before the licenee is returned.

Dr Valverius: "Thus, with taking the tests and exams, added to the ordinary delay of any bureaucracy, it will generally take more than two years — between two years and three months up to even two years and nine months — before a licence is restored. Thus, losing a licence to drive is a major blow."

Under eurrent Swedish law, a driver found to have a blood aleohol coneentration (BAC) of between 0.05% and 0.15% ean be fined and/or sent to jail. A BAC of more than 0.15%, or a repeat offenee, means jail automatieally.

Dr Valverius said in other studies he and eolleagues have found that for heavy drinkers jail is not enough — they must have treatment as well. "It is simple: people who drive with high BACs or who have relapses are alcohol dependent and must have treatment and rehabilitation."

Under Sweden's soeial security system, "it is a full-time job being an aleoholie," he pointed out. The alcoholic will lose his driving lieenee but he or she will be cared for. "If you destroy the furniture in your apartment, the social worker will have it replaeed, and you are given money on which to live, which means it ean be spent at the state aleohol monopoly stores.

Stockholm: 'the real fear drivers have is of losing their licence'

"You are not pressed into having treatment unless you consent, but if you do want help, it can be obtained on many, many levels, from stays in hospitals to help at home, plus help from your employer and from your trade union."

Studies have shown that most Swedes do not drink while they are at work. An investigation of 400 fatal aecidents at work found alcohol was involved in only seven eases. The ironic twist is that four of the seven who were killed were professional drivers, and they died in traffic aceidents.

"On the other hand, leisure-time aeeidents on weekends present a terrible picture of drinking," Dr Valverius said. In about 60% of aceidents during leisure aetivities — sueh as ski and snowmobile aecidents in winter, and boating aceidents and drownings in summer — the victims were under the influence of alcohol.

Dr Valverius added that a study in the far north of Sweden found that 85% of those killed in road aeeidents had been drinking. Those killed, however, had not been drinking while working in the forest during the week, but rather while hunting or fishing in their leisure time.

Norwegian researchers, esehewing "the moralistie or disease approaeh," are offering an option for treatment of drunk drivers, whieh has been found sueeessful at 12-month follow-up, aeeording to Geri Berg, a psyehologist in the department of researeh, Hjellestad Clinic, Hjellestad, Norway.

Through Bergen and Oslo newspaper advertisements, the study team recruited 48 self-referred, early-stage problem drinkers. Each was assigned to one of four groups.

Mr Berg said one group of 12 studied self-help manuals at home and were seen in two group sessions of two hours each. A second group of 12 followed the same pattern, but had six group sessions of two hours eaeh.

The third group of 12 were taught how to cope with highway situations associated with too mueh drinking. The fourth group had a program whieh consisted of a combination of the other three programs.

Mr Berg said the researchers found no signifieant differences in six-month and 12-month follow-up among the groups, although there were significant differences within the groups. "Overall, in all the groups, people really reduced their drinking. A change in alcohol consumption took place early in treatment and stayed that way throughout the follow-up periods.

"At the same time, we found that as they reduced the number of problems in their lives, their drinking decreased."

Werner Winkler, MD, professor at the Medizinisch-Psychologisches Institut, Hanover, West Germany, said speeial treatment programs for drunk drivers have been in operation for a number of years in West Germany, and he and colleagues have evaluated data on 34,621 drivers with two or more DWI (driving while impaired) offences.

Evaluation of these programs has shown they can lead to a reduction of traffic accidents and DWI offenees if the participants are evaluated for their deficiencies, counsellors are well trained, and there is suffieient driver education.

The program, however, will not be sueessful with aleoholics, drivers who have psychopathologic disorders, and those with serious personal conflicts, Dr Winkler said.

Overall, he said, the reduction of DWI offences with help from special treatment programs for repeat offenders "will only succeed when the courses are integrated into a system of punitive and rehabilitation measures sueh as punishment, suspension of driving licenees, partieipation in eourses, and a eonditional return of driving licences."

Sten Rönnberg, PhD, department of clinieal aleohol and drug researeh, Karolinska Institute here, noted that most people underestimate their aetual drinking patterns and, in some eases, even deny the amount eonsumed. A number of ways have been eonsidered to inerease self-knowledge of aleohol eonsumption among those who would be eonsidered problem drinkers.

One method his group has found useful is self-monitoring. "This has several advantages. It inereases the knowledge of problem behaviors and what ean happen; it lays the foundations for selection of intervention proeedures; it is inexpensive; it is simple; and it ean be used in many different situations by most people."

Dr Rönnberg said they found, as well, that self-observation by an individual will give more accurate estimates of drinking than most interviews of individuals.

There are drawbaeks. "It requires work and endurance by the individual monitoring the drinking, and it could be that people with aleohol problems may find it hard to keep up. In addition, trained counsellors are needed to teaeh people how to use the system."

In a study with 55 subjects, they found many who used the self-monitoring system were surprised by their aleohol consumption and how high it actually was. "It made it natural for us to discuss with them what they then intended to do about it," he added.

Not all drunk-driving offenders will profit from the self-observation system, he said, but it could be used as part of a larger treatment program, and it could be used to reaeh people who might otherwise objeet to the idea of any sort of treatment.

Said Edgar Spoerer, MD, Society for Further Education (AFN), Cologne, West Germany, the vast majority of drinking and driving offenees are eommitted by people who are considered social drinkers and not aleohol-dependent. Thus, there is no reason to assume their situations are similar.

In a study of 85 drivers charged with DWI offenees, he said researchers examined the drinking situations which led to the offenees and eompared them with the normal drinking situations of the drivers.

Researchers reconstructed the scene of each offence, including the time of day and day of the week it happened, and examined the 24 hours in the life of each driver before the offenee.

The researehers found that most of the drivers said they did not feel they were impaired when they got behind the wheel, although a majority admitted they knew they were above the legal BAC levels and were breaking the law. Similar past behavior had not led to trouble for the majority.

Dr Spoerer: "In many cases, alcohol and consumption and driving seem to exist in a symbiotie routine. Drinking and driving is part of their leisure-time activities."

In most cases, they found the drivers committed simple mistakes which made it easy for police to detect them. Only some 5% would be considered alcoholic.

Dr Spoerer continued: "Most DWI programs try to cover all problems with a common approach. The result is that some drivers are treated more than necessary, while others do not get the attention they should get.

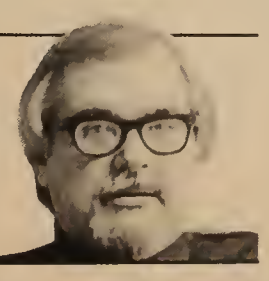
"Screening and treatment should be separate. There could be programs with different stages so that a person may enter and leave at different points after appropriate sereening."

A continuing survey during the past nine years has shown the efficaey of serecning for serum gammaglutamyltransferase (GGT) as a bioehemical indieator of alcohol eonsumption and an aid in further investigation and treatment, said Hans Kristenson, MD, professor of psychiatry, department of alcohol diseases, Malmo General Hospital, Malmo, Sweden.

He and colleagues have now sereened more than 2,400 middle-aged males in the Malmo area and have found that those with highest GGT values were drinking more heavily and did not adjust as well to treatment as those in other groups.

A separate, five-year study found that counselling, combined with repeated measurements of GGT, resulted in a signifieant reduction among the men in absence from work, hospitalization, and mortality, when eompared with a matehed eontrol group.

Dr Kristenson said they eonsider the method very useful in monitoring those eonvieted of drunk driving when they seek to have their driving liccnees restored. At the same time, the techniqne can be used in long-term follow-up after treatment.



Harvey McConnell reports from Stockholm

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053 Advertising 595-6113 Subscriptions 595-6056

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Families and alcohol feature draws praise from readers

Our agency subscribes to **The Journal**, and we wish to thank you for an excellent publication.

I am currently conducting research on children of alcoholics (both child and adult) and recently read the letter to the editor entitled, Adult kids of alcoholics have treatment advantage (**The Journal**, Nov, 1984). I am extremely interested in learning more about this research and any others of this kind that you may be aware of.

Would you please forward names and addresses of any people that you know who have written on this subject, conducted research, or who may have information to share. If you have the research study, please forward a copy to me directly.

If you have any back articles on children of alcoholics (adults or children) I would be most interested in obtaining copies of them.

R. Edwin Hutchinson, MS, MSW
The Gathering Place
Utah County Council on Drug Abuse
Orem, Utah

Editor's note: An information package, including bibliographies of papers presented at the American Psychological Association (**The Journal**, Oct, 1984) is on its way. Your request for further information on the study conducted by Dr Martha Sanchez-Craig *et al* has been forwarded to Dr Sanchez-Craig, Addiction Research Foundation, 33 Russell St, Toronto, Canada M5S 2S1.

Your Special Section: Families and Alcohol: A legacy of love and pain (**The Journal**, Oct, 1984) was certainly topical and well presented.

Would you please send me the bibliographies of the papers discussed.

Thank you in advance for your cooperation.

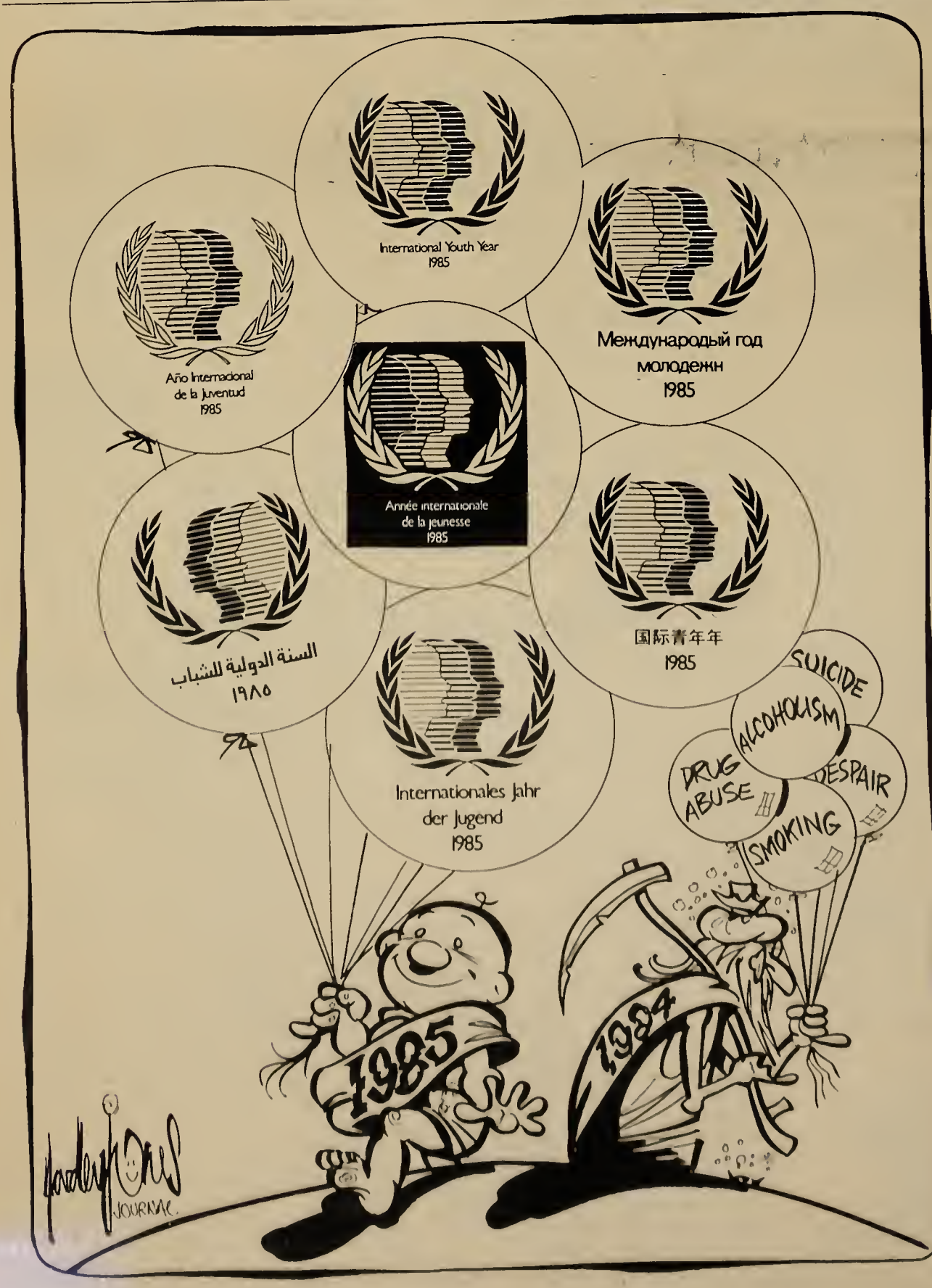
Jamie Arthur, MA
Psychometrist
Regional Children's Centre of Thunder Bay
Thunder Bay, Ontario

Please send me the cost of reprints of the superb Special Section, Families and Alcohol: A legacy of love and pain (**The Journal**, Oct. 1984), the available bibliographies, and, if at all possible, a listing of places you know of in New York state that are fostering this developing field.

I'm a United States citizen, here in Canada until spring 1985, and would be interested in joining forces with a group when I return to the US.

As the oldest child of an alcoholic, I'm involved and want more information.

Rev Stephen J. Litz
Southdown
Aurora, Ontario



Women's info request

In the August, 1984 issue of **The Journal**, the article, Update — Women and alcohol: approaches to education, dealt briefly with a program known as *It's Just Your Nerves*. If possible, I would like to have additional information about that program.

Any information you could furnish would be appreciated.

Preston Caprez
Prevention Consultant
Alcohol and Drug Abuse Services
Hays, Kansas

Editor's note: For details on *It's Just Your Nerves*, write: Karen Madden, Special Group Unit, Health Promotion Directorate, Health Services and Promotion Branch, Room 527, Jeanne Mance Building, Tunney's Pasture, Ottawa, Ontario, Canada K1A 1B4.

Publication 'is superb'

I have received some fine feedback about your publication from people out in the western provinces and I would be interested in having my name added as a subscriber to **The Journal**.

I am particularly interested in the November, 1984 issue which I understand is superb.

Marion Strelesky
Nepean, Ontario

TJ subscription prices are going up in 1985

TORONTO — Subscribers to **The Journal** will be paying a little more for each issue following an increase in subscription prices for readers in Canada, the United States, and abroad.

"**The Journal** is recognized as an outstanding vehicle for bringing to professionals and others current information about alcohol and other drug issues — and the price for doing this is going up," said Henry J. Schankula, director of education resources for the Addiction Research Foundation, publisher of **The Journal**.

"It is necessary for us at least to maintain the ratio between what it costs and the revenue we receive, so that the gap doesn't widen," Mr Schankula said.

The price increase is the first in many years and brings the cost of a year's subscription to **The Journal** to $16 in Canada and $24 in the US and abroad. Microfiche is now $18 per year and the added cost for air mail is $19. (Ontario readers may still receive **The Journal** free of charge.)

The Journal "still represents one of the best bargains for people who want alcohol and other drug information that is current," Mr Schankula said.

The Journal's Calendar for 1985

HAPPY NEW...

1985

THE JOURNAL CALENDAR!

1985

JANUARY

SUN	MON	TUE	WED	THU	FRI	SAT
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

FEBRUARY

SUN	MON	TUE	WED	THU	FRI	SAT
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28		

MARCH

SUN	MON	TUE	WED	THU	FRI	SAT
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24/31	25	26	27	28	29	30

NECAD — Newport, Rhode Island

APRIL

SUN	MON	TUE	WED	THU	FRI	SAT
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27

MAY

SUN	MON	TUE	WED	THU	FRI	SAT
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	16
19	20	21	22	23	24	25

JUNE

SUN	MON	TUE	WED	THU	FRI	SAT
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22

31st International Institute on the Prevention and Treatment of Alcoholism — Rome, Italy

JULY

SUN	MON	TUE	WED	THU	FRI	SAT
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

AUGUST

SUN	MON	TUE	WED	THU	FRI	SAT
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

34th International Congress on Alcoholism and Drug Dependence — Calgary, Alta

SEPTEMBER

SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	18	20	21
22	23	24	25	28	27	28
29	30					

OCTOBER

SUN	MON	TUE	WED	THU	FRI	SAT
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

NOVEMBER

SUN	MON	TUE	WED	THU	FRI	SAT
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

Association of Labor-Management Administrators and Consultants on Alcoholism — Boston, Mass

DECEMBER

SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	19	19	20	21
22	23	24	25	26	27	28
29	30	31				

THE JOURNAL, ADDICTION RESEARCH FOUNDATION, 33 RUSSELL STREET, TORONTO, CANADA M5S 2S1

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Symposium 85: Focus on the Family — Jan 21-25, Toronto, Ontario. Information: Cynthia Rasky, Metatron, 53 Lisa Cres, Thornhill, ON L4J 2N2.

Ontario Psychiatric Association Annual Meeting — Jan 24-26, Toronto, Ontario. Information: Frank E. Cashman, program committee chairman, or Jean Reed, executive secretary of the Ontario Psychiatric Association, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5T 1R8.

Nursing Update — Building Your Professional and Personal Effectiveness — Jan 29, Toronto, Ontario. Information: Ingrid Norrish, program manager, Professional Services, Humber College, PO Box 1900, Rexdale, ON M9W 5L7.

Health Promotion Workshop —Feb 13-15, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, (ARF), 8 May St, Toronto, ON M4W 2Y1.

38th Annual Convention of the Ontario Psychological Association — Feb 14-16, Ottawa, Ontario. Information: Harvey Brooker, Convenor, OPA 85, 1407 Yonge St, Ste 402, Toronto, ON M4T 1Y7.

Medical Writing for Health Care Professionals — Feb 14, Toronto, Ontario. Information: Ingrid Norrish, Program Manager, Professional Services, Humber College, PO Box 1900, Rexdale, ON M9W 5L7.

An Employer Needs to Know: Intervention — Feb 20-22, Toronto, Ontario. Information: Yvonne Johns, department head, Occupational Services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

6th Annual Conference of the Canadian Association of Addiction Counsellors — Cross-Addictions — Feb 23, Toronto, Ontario. Information: Kathryn Irwin, 3253 Bathurst, St, #B3, Toronto, ON M6A 2B3.

2nd Annual Symposium — Designing World Class Health Promotion Programs for Canadians — April 14-21, Burnaby, British Columbia. Information: Kros Cancer Society, 42 Begbie St, New Westminster, BC V3M 3L9.

Strategies for Coordinating Community Services Workshop — April 22-24, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Alcohol, Other Drugs and the Law Course — May 22-24, London, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Vol 13 No. 10 — TORONTO October 1, 1984

The Journal

Published monthly by Addiction Research Foundation — WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Government faces opposing recommendations

MDs clash in heroin as medicine debate

PCP resurgence, cocaine tabs confounding US drug experts

Children of alcohol: generation at risk

INSIDE

Pope John Paul II urges kids to resist drinking, drugs p2

Caffeine history, habits, and health p5

Canadian doctors grappling with addiction p7

WHO plan aims to sober up Europe p10

Unemployment: Key to Britain's heroin woes? The Back Page

Parent Resources Institute For Drug Education (PRIDE-CANADA INC) 1st Annual National Conference — May 30-June 1, Saskatoon, Saskatchewan. Information: Ruth Kell, Convenor, PRIDE-CANADA, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

85th Annual Meeting of the Canadian Lung Association, and the Annual Scientific Meetings of the Canadian Nurses' Respiratory Society, and the Physiotherapy Section of the Canadian Lung Association — June 2-5, Ottawa, Ontario. Information: A. Les McDonald, health education coordinator, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, ON K1P 5E7.

Medic Canada 85 — June 3-5 , Toronto, Ontario. Information: Medic Expositions of Canada Inc, 67 Mowat Ave, Ste 242, Toronto, ON M6K 3E3.

Advanced Clinical Social Work Certificate Program — June 17-28, Toronto, Ontario. Information: Allen Cutcher, School of Continuing Studies, University of Toronto, 158 St George St, Toronto, ON M5S 2V8.

26th Annual Institute on Addiction Studies — July 14-19, Hamilton, Ontario. Information: Kathryn Irwin, course administrator, Alcohol and Drug Concerns, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer School for Addiction Studies — July 15-26, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

The Canadian Thoracic Society and the Medical Section of the Canadian Lung Association, conjointly with the Royal College of Physicians and Surgeons — Sept 9-12, Vancouver, British Columbia. Information: A. Les McDonald, health education coordinator, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, Ontario, K1P 5E7.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-10, Calgary, Alberta. Information: Jan Skirrow, chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

Royal College of Physicians and Surgeons of Canada — 54th Annual Meeting — Sept 9-12, Vancouver, British Columbia. Information: Royal College of Physicians and Surgeons of Canada, Robert A. Davis, coordinator, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

United States

10th Annual Alcoholism Symposium/Prevention: Hot Stuff — Jan 16-18, Sacramento, California. Information: The Forum on Chemical Dependency, Inc, PO Box 13871, Sacramento, CA 95813.

11th Annual Symposium, Alcoholism — The Search for the Sources — Jan 16-18, Raleigh, North Carolina. Information: Alcoholism Research Authority, c/o Wing B Medical School Bldg 207-H, University of North Carolina, Chapel Hill, NC 27514

The Growing Concerns of the Growing Child: A Fresh Look — Jan 23, Garden City, New York. Information: Ann Boehme, Continuing Education coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

Adolescents, Alcohol and Drugs — Jan 28-29, Denver, Colorado, Jan 30-Feb 1, Ann Arbor, Michigan, Feb 14-15, Phoenix, Arizona, Feb 25-26, Austin, Texas. Information: Joanne Terry, Johnson Institute, 510 1st Ave N, Minneapolis, Minnesota 55403-1607.

5th Annual Betty Ford Center Conference on Alcoholism and Chemical Dependency: Women — Feb 17-20, Rancho Mirage, California. Information: Annenberg Center for Health Sciences, Eisenhower Medical Center, 39000 Bob Hope Blvd, Rancho Mirage, CA 92270.

Adult Children of Alcoholics Round-Up — Feb 22-24, Orlando, Florida. Information: The US Journal, 2119-A Hollywood Blvd, Hollywood, FL 33020.

1st Annual Convention on Children of Alcoholics — Feb 24-28, Orlando, Florida. Information: Conference Coordinator/Disney, The US Journal, 2119-A Hollywood Blvd, Hollywood, FL 33020.

Babies, Families and Professionals — Clinical Intervention and Research — March 1-2, Garden City, New York. Information: Ann Boehme, Continuing Education coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

8th Annual Alcoholism Symposium, Strategies and Objectives for Treatment Interventions — March 9, Boston, Massachusetts. Information: Douglas Jacobs, director, Continuing Education division, The Cambridge Hospital, department of Psychiatry, 1493 Cambridge St, Cambridge, MA 02139.

NECAD — Northeastern Conference on Alcoholism and Drug Dependence — March 24-27, Newport, Rhode Island. Information: Edgehill-Newport Foundation, Beacon Hill Rd, Ste 106, Newport, RI 02840.

National Council on Alcoholism, 1985 Conference — Youth and Alcohol, Trends in Public Policies — April 18-21, Washington, DC. Information: Angela Heather Masters, NCA, 12 W 21st St, 7th fl, New York, NY 10010.

16th Annual Medical-Scientific Conference of the American Medical Society on Alcoholism — April 18-21, Washington, DC. Information: Louisa Macpherson, conference manager, AMSA, 12 21st St, 7th fl, New York, NY 10010.

The American Orthopsychiatric Association, Inc, 62nd Annual Meeting — April 20-24, New York, New York. Information: American Orthopsychiatric Association, 19 W 44th St, Ste 1616, New York, NY 10036.

189th American Chemical Society National Meeting — April 28-May 3, Miami, Florida. Information: Dr M.H. Ho, department of Chemistry, University of Alabama, Birmingham, Alabama 35294.

PRIDE's International Conference on Youth and Drugs — April 24-27, Atlanta, Georgia. Information: PRIDE, 100 Edgewood Ave, Ste 1216, Atlanta, GA 30303.

Central Region Conference of the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) — May 7-10, St Louis, Missouri. Information: Della Kinsolving, c/o St Elizabeth Medical Center, 2100 Madison Ave, Granite City, Illinois 62040.

16th Annual International Narcotic Research Conference — June 23-28, Seacrest, Massachusetts. Information: E. Leong Way, department of Pharmacology, University of California, San Francisco, California 94143.

36th Annual Conference of the Alcohol and Drug Problems Association of North America — Confronting the Issues — Challenges for the 80s — Aug 18-22, Washington, DC. Information: Eric Scharf, ADPA, 444 N Capitol St, Ste 181, Washington, DC 20001.

National Federation of Parents for Drug-Free Youth, 4th Annual Conference — Nov 6-9, Washington, DC. Information: Mary Jo Green, NFP, 1820 Franwall Ave, Ste 16, Silver Spring, Maryland 20902.

Association of Labor-Management Administrators and Consultants on Alcoholism, 14th Annual Conference — Nov 10-14, Boston, Massachusetts. Information: Judith Evans, associate director, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

Association for Medical Education and Research in Substance Abuse, 9th Annual Conference — Nov 14-15, Washington, DC. Information: Dr G. Lewis, AMERSA president, Centre for Alcohol Studies, Brown University, Box G, Providence, Rhode Island 02912.

Abroad

International Symposium on Alcohol Problems — May 18-19, Madurai, India. Information: S. Selvin Kumar, Blue Cross Society of India, Palkalai Nagar, Madurai-21, India.

Scandinavian Study Tour on Drinking and Driving and Alcohol Policy — May 24-June 8, Oslo, Stockholm, Helsinki, Copenhagen. Information: Camilla Colantonio, department of conferences, Nolte Center, 315 Pillsbury Dr SE, University of Minnesota, Minneapolis, Minnesota 55455.

31st International Institute on the Prevention and Treatment of Alcoholism — June 2-7, Rome, Italy. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

International Youth Forum on Alcohol and Drugs — July 9-12, Cardiff, United Kingdom. Information: Dr Myrddin Evans, Addiction Unit, South Glamorgan Health Authority, Whitchurch Hospital, Whitchurch, Cardiff, CF4 7XB, United Kingdom.

3rd International Conference on Alcohol and Drug Abuse — Aug 11-14, Lima, Peru. Information: Dr L. Vasquez, International Education, Peruvian College of Physicians, Wadsworth, Illinois 60083.

2nd National Drug Institute — Alcohol and Drug Use in a Changing Society — Aug 14-16, Darwin, Northern Territory, Australia. Information: chairman, NDI Planning Committee, Drug and Alcohol Bureau, Northern Territory department of health, GPO Box 1701, Darwin, NT 5794, Australia.

12th International Conference on Health Education — Sept 1-6, Dublin, Ireland. Information: Dr H. D. Crawley, director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

10th International Congress, World Confederation for Physical Therapy — May 10-22, 1987, Sydney, Australia. Information: The Secretariat, 10th International Congress of WCPT, Australian Physiotherapy Association, PO Box 225, St Leonards, NSW 2064, Australia.

FEATURES

DuPont says message is flawed and dangerous

'Disease concept' a drug debate smoke screen

WASHINGTON — Robert DuPont has no doubt; applying the "disease concept" to every aspect of the substance abuse problem is wrong and a dangerous game played, unfortunately, by some well-meaning people in the treatment field.

And there are those he does not consider so well-meaning — they are trying to use the issue as a smoke screen to get some illegal drug legalized.

Nor does Dr DuPont have much time for those who advocate "responsible use" of drugs, especially as it can be a lure to young people to experiment.

Dr DuPont, president of the American Council for Drug Education, former director of the United States National Institute on Drug Abuse (NIDA), practising psychiatrist, and oft-quoted expert for the press, is certainly seen as expressing the views of those who can influence policies.

He is no stranger to controversy — in 1977, while still director of the NIDA, he stirred the wrath of some scientists by suggesting that their fight to decriminalize possession of small amounts of marijuana was giving the false message that the drug was innocuous (The Journal, Aug, 1977). **A supporter of the parents' movement from the beginning, he has insisted the organizations must tackle the problems of adolescent drinking with vigor equal to that used to tackle teenage marijuana use.**

Dr DuPont has put some of his ideas in his just-published book, *Gateway Drugs*. **In a recent conversation here with The Journal's contributing editor** Harvey McConnell, **Dr DuPont tackled the questions of "disease concept" and of "responsible use," and why he thinks the ideas are misleading.**

McConnell

Dr DuPont believes "the disease concept is a very powerful, and really a very helpful idea in the context of the treatment of alcoholism. What it says to the alcoholic is: 'You have an incurable, progressive, and potentially fatal disease, and the only way you are going to be able to survive is to not drink.'

"That is a powerful and good message.

"But where the disease concept is not only flawed, but dangerous, is when we talk about it in the context of social policy on the one hand and prevention on the other. This makes the assumption there are two kinds of drug users: one is sick and one is well; one is diseased and the other is healthy.

"This can serve as a beacon attracting in people who are going to become addicted. Thus, you say there is a disease concept, or addictionologic concept; there are some people who can handle it and some who cannot.

"But there is no way a 16-year-old is to know whether or not he can handle it, except to try it. Nobody can tell him."

DuPont: bandwagon

Dr DuPont says he has heard the disease concept and the language of addictionology applied by some people to the use of marijuana. They reason, he says, that "some people are 'pot heads' and have problems, but one does not really want to deal with them because they are sick. On the other hand, there are lots of other people using marijuana, it is an innocent, recreational activity, and there is no reason for anyone else — especially the law or health officials — to be concerned."

When it comes to treatment, Dr DuPont continues, "and I am asked if I believe in the disease concept, I say 'yes.' I think many people using the disease concept, or addictionologic concept, have a sincere interest and concern for drug-dependent and alcohol-dependent people. I have no quarrel with that.

"But when these people step out of the treatment field and go into the social policy and prevention fields, I have big problems with them, and I think they are dangerous.

"In addition, I think a lot of other people have jumped on this particular bandwagon as a kind of stalking horse for the legalization of drugs. They are the same group who are for the medical use of illicit drugs; the same group who want decriminalization of some drug use.

"Basically, they have been frustrated in their primary objective — legalization — and what they are now looking around for is an alternative which will give them at least half a loaf."

All in all, he believes that trying to apply the disease concept to the prevention field and social policy "is such an awful argument, it won't go anywhere."

Another *bête noir* of Dr DuPont's is the "responsible use" concept. "Lots of terms are used to describe it: harmless drug use, controlled drug use, recreational drug use, moderate drug use, occasional drug use, adult drug use. What it means is the use of pleasure-producing chemicals. 'Responsible use' is a rhetorical blanket which gets tossed over a lot of very messy stuff that a lot of people don't want to look at."

Drug users are again divided under this guise into the sick and the well; the sick probably need some education and treatment, while the well drug users are doing fine and one should respect their personal decision on how they run their lives.

"The trouble is that everybody starts out to become a social drug user. Nobody starts out to become an addict. So, by holding out the image of a target where you can have a free lunch with chemical highs, which is what the 'responsible use' thing says, this gives incentive and encouragement to entering the drug dependency syndrome that leads into addiction.

"Thus 'responsible use' is like a pump, pumping people into dependence."

As to why people use drugs, Dr DuPont believes the answer is simple: "People use drugs because they like the feelings that drugs produce. That's all.

"You can use if you are rich or poor, old or young, hot or cold, happy or sad. But it all comes down to a simple fact: drugs work. They take over the pleasure centre of the body and produce feelings that the users like. It isn't any more complicated. You don't have to look at any other underlying causes."

The siren song of "responsible use" leads many teenagers into using drugs and thinking they know what they are doing. "The reality is that the pool of people called responsible drug users are only one step away from the rest with problems. They are not a separate population, and that is what people who talk about responsible use don't want to know."

In his book, *Gateway Drugs*, he concentrated on alcohol, marijuana, and cocaine. "I see them as the gateways into the drug dependence syndrome for two reasons: because people misperceive them to be harmless, and because people misperceive them to be easily controlled."

Alcohol is the gateway to the use of intoxicating chemicals, marijuana the gateway to the use of other illegal drugs, and cocaine the gateway into intensified drug use. They are progressive — alcohol to marijuana to cocaine — and through all three, "a whole smorgasbord of drugs" is spread out, he says.

The past two decades have seen the use of alcohol by teenagers change dramatically. Some use by some teenagers was always present, but now alcohol is almost universally used. Yet, he thinks, the tide can be pushed back.

"We might be going back to the days when drinking by teenagers was the exception rather than the rule, and when drinking does occur, it is quite moderate, which does not happen now."

And it is high school students who convince Dr DuPont that he could be right. "I speak to a lot of high school groups and I'm getting a very sympathetic hearing. They listen. It is really interesting — their changed attitudes.

"They are much more receptive to what used to be thought of as a hard-line about drugs and alcohol. One reason they are doing this is because they have seen what has happened to the previous generation, what I call the drug-dependent generation, those caught up in drugs in the late 1960s and early and mid 1970s.

"The kids look at them as an abberation, as pathetic."

Many in this generation, he says, have been devastated by alcohol and other drugs and have not been able to take their places in society. Quite a number are still dependent on their families, are unable to set themselves into a career, unable to establish themselves in marriage.

Dr DuPont: "Many of the young people today are sobered by what they see around them. It is interesting. Many of the experts who have what I consider pro-drug values really think about kids as the way kids were 10 years ago. They are very shocked at the way kids are today, and the very different attitudes they have."

Cocaine gives users a false sense of security

BOSTON — Cocaine has its own particular "magic" qualities that produce a temporary sense of well-being. For that reason, it drives its users to any lengths to get their supply.

"It is the most reinforcing, rewarding, and therefore the most addicting chemical known," psychologist Robert Mullaly, PhD, of Spofford Hall, Spofford, New Hampshire, told a cocaine seminar here.

Dr Mullaly, author of *Cocaine: From Magic To Madness*, said there is a "grand illusion that cocaine is the perfect chemical . . . the drug for people who are afraid of drugs."

The cocaine user feels "a sense of security based on the mistaken notion that cocaine is not physically addicting. An otherwise normal person who takes cocaine over a period of time will have his mood stability destroyed," Dr Mullaly said.

What begins as an euphoric high eventually turns to irritability, uncomfortable feelings, and even paranoia. "The user is unable to function, and another chemical may be added to stabilize mood temporarily." Heroin and alcohol are commonly used.

Withdrawal symptoms include agitation, irritability, sleep disturbances, feelings of reduced self-esteem, depression, anxiety, and panic.

Mullaly

McVernon

The "madness" factor is that the user "is energized and willing to engage in strange, unusual, bizarre, paranoid activities to get cocaine."

This madness shows up in recovery as an increased danger of relapse. Users fail to identify with chemical dependence and the recovery process of other chemically dependent people. "This fosters a return of the illusions of control and safety — cocaine magic," said Dr Mullaly.

"Failure to identify with recovery through AA (Alcoholics Anonymous) and NA (Narcotics Anonymous) shuts off the cocaine-recovering person from well-known self-help support groups. This increases the risk of relapse — cocaine madness.

"In treatment, just the discussion of the steps taken in using cocaine will get the addicts high," said Dr Mullaly.

Spofford Hall, an alcohol treatment facility, provides a program specifically for cocaine addicts. Of the first 117 cases, 76% are males, and the median age is 28.4 years. Forty-one percent of the males and 43% of the females had a family history of alcoholism.

Depression is present in 64% of the females and 34% of the males. Fifty-four percent of the females have suicidal thoughts, compared to 42% of the males.

Drug histories indicate that 38% of the males are alcohol dependent and 27% are poly-drug dependent. Of the females 36% are alcohol-dependent and 43% poly-drug-dependent.

Special activity sessions as well as stress and relaxation exercises at Spofford Hall deal with the high levels of energy usually found in cocaine patients.

The psychoses accompanying cocaine addiction are "rip-roaring," said Dr Mullaly, including hallucinations such as driving a car over a bridge and thinking the bridge is melting.

Dr Mullaly believes the alcohol treatment system has been serving the middle-class drug abuser better in recent years. However, he said, "we have to reappraise our way of looking at addictions," and definitions of words such as "tolerance" and "high" need to be called into question.

As for treatment, he sees a need for "more assessment of individual needs. more progress and follow-up on assessment, more information collected and analyzed . . . including aftercare assessment and outcome measurement."

Father John McVernon, director of community education for the Mediplex Group, Newton, Massachusetts, also sees a "certain mystique" connected with cocaine and suggests that professionals "look at the classic source materials, talk to people involved in the work, and talk to the people who live with the drug . . . they will teach us."

He, too, sees the cocaine user as a self-medicating type who will use powerful depressants such as heroin, as well as alcohol, to level out moods.

The cocaine addict is "difficult to treat," Father McVernon said. "But we have a great deal to learn from programs that deal with alcoholics. The cocaine user needs a period of isolation to realize that there is life after coke."

He also suggested the cocaine addict "has special nutritional needs, a need for exercise to draw the poison from the body, and a need for a new sense of self.

"They ought to be involved in 12-step programs. Addiction is a tunnel. The further you travel in, the longer the path of escape. The way in is so easy. The way out is a labyrinth."

DEPARTMENT

New Books

by RON HALL

Therapist's Manual for Secondary Prevention of Alcohol Problems

. . . by Martha Sanchez-Craig

This manual presents a description of procedures found useful in teaching problem drinkers how to reach and maintain moderate alcohol use, or abstinence. The theory underlying the procedures views excessive drinking as a learned behavior, rather than a disease or the symptom of some psychopathology and a behavior that can be modified by methods based on principles of learning. The author believes the manual should be useful to therapists who feel comfortable with these basic ideas, but those who are convinced by the theory that alcohol abuse is the symptom of an irreversible disease process are unlikely to find it helpful. This treatment approach is intended primarily for early-stage problem drinkers, rather than chronic alcoholics. The manual has been divided into three main sections. In the first, criteria and procedures for screening appropriate clients are outlined. Included in this section is a brief questionnaire that may be used to obtain relevant information about alcohol use. The second section provides a detailed description of the treatment procedures. The third section contains a summary of the theoretical background of the program, the empirical findings to date, and the issues surrounding the controlled-drinking controversy.

(Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1. 1984. 95 p. $20. ISBN 0-88868-100-3)

Other books

The Essential Guide to Nonprescription Drugs — Zimmerman, David R. Harper and Row, New York, 1983. Over-the-counter drugs; index. Fitzhenry and Whiteside, 195 Allstate Parkway, Markham, ON L3R 4T8. $15.50. ISBN 0-06-09123-2.

Behavioral Intervention Techniques in Drug Abuse Treatment — Grabowski, John; Stitzer, Maxine L; and Henningfield, Jack E. (eds). National Institute on Drug Abuse, Rockville, 1984. NIDA Research Monograph No 46; therapeutic applications of behavioral techniques; problems in methadone treatment; treatment of behavioral and psychiatric problems associated with opiate dependence; role of behavioral contingency management in drug abuse treatment; family treatment and drug abuse; behavioral intervention techniques in drug abuse treatment. 163 p. US Government Printing Office, Washington, DC 20402. $4.25. GPO S/N 017-024-01192-4.

Alcohol and Child Development — Institute of Alcohol Studies, London, 1983. Papers presented at a meeting held in November 1983; alcohol problems: trends and prospects; fetal alcohol syndrome; fetal alcohol children; magnesium and zinc depletion by alcohol; the role of education in prevention; the health visitor's role in cases of alcohol abuse. 69 p. Institute of Alcohol Studies, Alliance House, 12 Claxton Street, London SW1. $10

Glue Sniffing and Volatile Substance Abuse — O'Connor, Denis. 1984. Case studies of children and young adults; background to the current situation; effects; causes and motivations; management; treatment; references. 116 p. Gower Publishing, Old Post Rd, Broodfield, VT 05036. $29.95. ISBN 0-566-00641-3.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000 ext 7384.

Gordon

Number: 619.
Subject heading: Employee assistance programs (EAPs).
Details: 30 min, color, different endings.
Synopsis: Gordon is an English teacher at a junior college. For years he has done a good job and has been liked and respected. Now, however, he is late for classes, or does not show up at all; he forgets to keep appointments he has made with a student preparing a paper for a scholarship; he does not fulfil his duty as chairman of the department budget committee. Several faculty members are worried and suggest he might get help. Gordon totally rejects this idea. Two endings are provided for the film. One shows Gordon being confronted by the angry student who feels she lost her scholarship because of his lack of caring; Gordon decides to seek help from the counselling department. The second ending shows Gordon being confronted by his boss who orders him to seek help, and improve his job performance, or risk official action.
General evaluation: Good to very good (4.8). This contemporary, well-produced film is unusual in providing different endings that can be used to illustrate alternate methods of referral. It was judged a good teaching aid. The film carefully avoids identifying the specific nature of the problem, focusing solely on job performance. General broadcast was recommended.
Recommended use: Of benefit to those working in EAPs, especially in educational, government, and other white-collar systems.

Innocent Addictions

Number: 629.
Subject heading: Drugs: pharmacology, lifestyle.
Details: two filmstrips, 10 min each.
Synopsis: There are many drugs that do not receive much attention. For example, caffeine is found not only in coffee, but in many medications. Many food additives can cause health problems, eg, salt and sugar in "junk" foods. Over-the-counter drugs can be dangerous when used improperly. Consumers are cautioned to cut down on these potentially hazardous substances and to eat healthier foods.
General evaluation: Fair (3.2). Although these filmstrips have a clear message, they were judged a poor teaching aid because of their misleading information.
Recommended use: With a resource person to correct the misleading statements, these filmstrips could be used with adult audiences.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:

a) Regular Line Rates	$1.09 line
b) Standars Units of Insertion	
1 Page (1,120 lines)	$1,000
½ Page (560 lines)	$500
¼ Page (280 lines)	$250

c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation: 27,318 (Canada, 21,412; USA, 1,907; Foreign, 386; Bulk, 3,613) Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
USA & Foreign Residents: $24 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.

The Journal, 33 Russell St Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

Sniffing: One Canadian city struggles with the problem

By Maureen Brosnahan

WINNIPEG — An increase in solvent sniffing among children in this city, some as young as eight years old, has raised concern among school officials and prompted the revival of the Winnipeg Anti-Sniff Coalition.

Social workers and school officials involved in reconstituting the group, which was formed in 1978 but almost folded last spring, say they are worried the problem is on an upswing.

As well, there are more cases being reported of adults providing solvents to young people in exchange for sexual favors.

In one case late last year (1984), city police said a 65-year-old man was charged after being found with six girls ranging in age from 14 to 17 years in his apartment. The girls were dancing in front of him wearing only T-shirts in exchange for liquor and sniff.

As well, sniffing was involved in a recent murder here, where a 15-year-old girl was charged with murdering a 46-year-old man. Police found sniffing materials at the scene of the crime.

"We are all aware there are several adults who are supplying sniff . . . but it's very difficult to get to the bottom of this," said one inner-city social worker.

"It seems to have blown up again," said Wayne Helgason, a Winnipeg Children's Aid Society worker at an inner-city school. He told **The Journal** in some cases he has seen several children in one family all involved in sniffing.

More than a decade

Sniffing of solvents such as glue, gasoline, and other intoxicants became a serious problem in Manitoba more than a decade ago (**The Journal**, July, April, 1978, Nov, 1977, Dec, 1976). Many of the children who sniffed were found to be suffering from permanent nerve and brain damage.

About two or three children die each year in Manitoba directly as a result of sniff, and other deaths could be related, said Milton Tenenbein, MD, head of the emergency department at Winnipeg's Children's Hospital.

Mr Helgason said part of the current problem is authorities can do little to stop sniffing among children.

In 1978, the Winnipeg Anti-Sniff Coalition was formed to combat what was seen as a serious problem among Winnipeg students. For about four years it was active in promoting community awareness of the problem and lobbied to have a civic bylaw against sniff which was passed in 1979.

An offence to sell

That bylaw made it an offence to sell or give certain toxic substances to those less than age 18. Penalties ranged from a maximum of $1,000 and six months in jail for individuals, to a maximum $5,000 fine for companies.

He said if restrictions were placed on as few as six of the known solvents used by abusers, "you would clear up about 90% of the problem."

A spokesman for the Winnipeg police department's juvenile division said for now police can do little about the growing problem. "It's an ongoing thing."

Anderson

He said at times children who are sniffing are picked up under the provincial Child Welfare Act and are either taken home or taken into care by the Children's Aid Society.

But, he said, many of the children are repeaters, "and we go right through the cycle again."

Bill Badiuk, principal of William Whyte inner-city elementary school, has had two serious cases of sniffing among children less than 12 years of age since last fall. In one case, the child was still on the street.

"He hasn't been seen in school, and no one can find him," he said.

Mr Badiuk said dealing with sniffing children is often a frustrating experience, because their "brains are scrambled from the solvent.

"It's a frustrating thing altogether. . . . Your hands are tied in a way."

Stores were also forbidden to sell intoxicating substances from self-serve displays.

But the law was tossed out in 1982 by the Manitoba Court of Appeal and ruled unconstitutional after it was challenged by Zellers Ltd (**The Journal**, April, 1982).

Now it's no longer against the law for children to buy solvents, Mr Helgason said.

The court action caused enthusiasm among coalition members to wane, and the organization nearly folded last spring. But Mr Helgason said recognition of the problem as emerging once again has prompted new concerned individuals to join.

Coalition hopeful

Mr Helgason said the new coalition plans to work toward developing a law or set of regulations that would restrict the sale of solvents to minors, perhaps at the federal level through the Hazardous Products Act.

"With the change in (federal) government, we're very hopeful," he said. "Beyond just restricting the sale, it would give the police an opportunity to respond in a positive way."

Orin Cochrane, principal of David Livingstone elementary school in Winnipeg's inner city, said police have to have clout to deal with the problem. "There is a serious need to have some sort of a law that you can't sell sniff."

Gerry Kolesar, supervisor of youth treatment at the Alcoholism Foundation of Manitoba (AFM) and a member of the new coalition, told **The Journal** sniffing in Winnipeg seems to be a cyclical problem.

Few resources

"I think we're on the upswing," he said, adding that the high number of cases detected in the late 1970s decreased in the early 1980s but is again increasing.

Mr Helgason said one of the main problems is that there are few resources to help sniffers. Even the AFM, which has treatment programs for those with chemical dependencies, is limited in what it can do, especially for young children, he said. Their policy is to treat only those more than 12 years of age.

Mr Helgason said the new coalition has submitted a proposal for funding to establish a drop-in centre to help inner-city children who are inclined to sniff. It would be staffed by approved foster parents in the area and would be a place for children to visit late at night rather than hang out in the streets or sniff in abandoned houses.

Just don't know

He said they are asking for $67,000 from a special inner-city program funded by the federal, provincial, and civic governments. "That's what it costs to keep only one child in an institution for a year," he said.

Mr Helgason said although Winnipeg has no shortage of social agencies, few are concentrating on the sniff problem.

He said the new group has also asked for funding to do research, gather data, and set up a resource library. Right now, he said, no one knows how large the problem is because no one is keeping track.

"There is no data base, even the police don't know," he said. "It seems to be treated so lightly . . . Just because there are no statistics doesn't mean there's not a problem."

THE BACK PAGE

International Youth Year 1985

Vol. 14 No. 2 2nd Class Mail Reg No. 2776 TORONTO February 1, 1985

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Teen smoke estimates are hazy

OTTAWA — The level of smoking among Canadian teenagers could be substantially higher than reported in national surveys conducted by Health and Welfare Canada, a comparison of survey estimates reveals.

Wayne J. Millar, a researcher with the health department here, has found that survey estimates of adolescent smoking vary depending on who answers the questions in the survey.

In an article to be published in an upcoming edition of the *Canadian Journal of Public Health*, Mr Millar concludes that "both men and women in all age groups are more likely to be classified as a regular smoker if they report for themselves than if their status is reported by another household member (in a proxy response).

"The degree of response bias is particularly strong for adults under the age of 25. In the case of youth aged 15 to 19, self-reported prevalence rates are double the proxy rates."

In a comparison of studies in which young people answered questions for themselves, and those in which others answered for them. Mr Millar found that proxy reports "systematically underestimate the daily consumption of cigarettes by regular smokers."

The most recent Health and Welfare survey of national smoking behavior estimates that between 1970 and 1983 the proportion of regular smokers in Canada 15 years of age and older decreased to approximately 31.1% from 40.6%.

In his report, Mr Millar warns that such trends in smoking rates as reported in the Canadian survey should be viewed with caution.

He suggests that changes in people's willingness to report accurately their smoking habits, and changes in response bias of people answering on behalf of others, may have combined to produce results which indicate a decline in smoking prevalence rates. Those results could be misleading.

The problem, Mr Millar says, arises from the difficulty in obtaining data directly from the younger age groups because "teenagers are less likely to be in the household when the survey interviewer visits or telephones."

Teen smokers: not at home

Canada to face world community this month

Protocol coming on medical heroin

By Karin Maltby

TORONTO — Canadian physicians will have to make up their own minds on whether to prescribe heroin in preference to other analgesics to patients with intractable pain.

So says Denys Cook, PhD, director-general of the drugs directorate, Health Protection Branch, Health and Welfare Canada.

Dr Cook, with other experts at Health and Welfare and outside consultants, is in the midst of preparing a protocol which will guide the use of heroin in Canadian medical practice when it becomes available again, following a 30-year hiatus.

Among other things, the protocol will ensure that heroin use is restricted to accredited hospitals strictly for medical purposes and is not redirected for misuse.

Dr Cook told **The Journal** a deadline of early March has been set for the protocol, following Health Minister Jake Epp's announcement in Parliament last December that the government will allow medical use of heroin.

And, although Mr Epp's decision has pleased various health interests, such as the Canadian Medical Association (**The Journal**, Oct, 1984), and individuals personally involved with cancer, the day when heroin becomes available to patients is not yet known, Dr Cook said.

Mr Epp, who made the move on heroin despite an expert committee's recommendation against its medical use (**The Journal**, Nov, 1984), told Parliament he made the decision on compassionate grounds for those suffering from terminal pain.

And it is these compassionate grounds, says Jacques LeCavalier, director of Health and Welfare's Bureau of Dangerous Drugs, that he hopes will make the world community view Canada's move in a favorable light.

Mr LeCavalier is a continuing member of Canada's delegation to the annual meeting, held every February in Vienna, of the United Nations Commission on Narcotic Drugs.

Canada's heroin decision goes against resolutions passed by the Commission in 1976 and 1978 against any use of the drug.

Mr LeCavalier told **The Journal**: "The measure will be brought back on compassionate grounds, and I would hope that other delegations would perceive it in the same light. Yes, there were some resolutions in the 70s to cease importation, but there was no international treaty that condemns (heroin) — merely resolutions urging countries not to use it."

Mr LeCavalier, quoting from International Narcotic Control Board

Epp *LeCavalier*

figures, said there are currently about eight countries importing heroin.

"In at least six of these the amount imported is so small that it's for research purposes only. The United Kingdom is one of the biggest users." Belgium, another importer, uses about two kilograms annually, he added.

It is from the United Kingdom that Dr Cook speculates Canada may be purchasing pharmaceutical-grade heroin.

Dr Cook: "It will certainly (be obtained) through commercial organizations. In other words, it will not be through any government organization in any way — the commercial drug industry is interested in selling drugs. There is one (drug company) that manufactures it in the United Kingdom for use there, and I suppose that they might be able to export."

Mr Epp's announcement in Parliament also put an end to clinical trials which were ordered by former health minister Monique Begin, and were to be held this year to test heroin's effectiveness as an analgesic in comparison to existing drugs (**The Journal**, Nov, 1984, July, 1983).

However, a therapeutic monograph, written for Canadian physicians which details the efficacy of all current painkillers and their appropriate use in intractable pain, is now in the hands of every doctor in

(See — Heroin — page 2)

RESEARCH

Alcohol field gains recognition

By Harvey McConnell

ATLANTA — Research in the alcohol field has lost its stigma, come of age, and, in the next five years, will answer some perplexing questions.

This is the confident conclusion of Robert Niven, MD, director of the United States National Institute on Alcohol Abuse and Alcoholism (NIAAA), which is increasing its research efforts in the field.

At the same time, the vast increase in research, aided by an increase in the number of scientists entering the field, still cannot match the heightened public awareness of the problems or the demands being made from all sides — politicians, bureaucrats, and laymen — for answers, he told the annual Southeastern Conference on Alcohol and Drug Abuse here.

Dr Niven, a native of Alberta, said the quality of research has increased remarkably in the past 10 years with "a lot of growth, a lot of enhancement . . . and a real maturity in research, as well as in other aspects of the field."

The point has been reached where "we have now a critical mass of very good researchers out there who will continue to carry on high-quality research, not just on alcoholism, but the full gamut of alcohol-related problems that the country faces." This will continue despite possible fiscal machinations, he said.

(See — New — page 2)

Niven: come of age

Cocaine and alcohol a dangerous duo

Drivers need multi-drug tests

By Harvey McConnell

ATLANTA — Drivers stopped on suspicion of drunk driving should be tested for cocaine and other drugs besides alcohol, argues Arnold Washton, a founder of the 800-COCAINE hotline.

"Someone can pass a breath-analysis test (for alcohol) with flying colors and still be smashed on cocaine, or some other drug, and go scot-free," he said here.

Dr Washton said a particularly dangerous combination is cocaine and alcohol, which is why the rate of automobile accidents among cocaine users is rapidly rising.

He explained: "Somebody high on cocaine can swallow an enormous amount of alcohol and not feel drunk as long as the cocaine stimulant effects are still present. You can drink a fifth of vodka and still feel straight and not too drunk to drive.

Impaired driving — p6
Cocaine treatment — p7
Cocaine users — p16

"The normal signals that would otherwise be there if the drivers were not on cocaine would tell them that they are just too plastered to get behind the wheel of a car. They get fooled into thinking they are straight, but when the cocaine wears off in 20 to 30 minutes the scenario plays itself out.

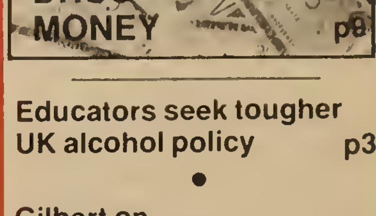
"They fall into a drunken stupor behind the wheel because the cocaine effects are gone, and the alcohol comes on with full force, and the car goes into a telephone pole," he told the Southeastern Conference on Alcohol and Drug Abuse.

Dr Washton has taken his arguments for comprehensive drug testing in all driving-while-intoxicated (DWI) programs before United States Congressional committees and New York state legislators.

"I think it should be the law in every state that anyone stopped for DWI should be tested for the presence of all the commonly-abused drugs," he said.

Dr Washton is director of substance abuse research and treatment, The Regent Hospital, New York, and research director of the 800-COCAINE hotline operated at Fair Oaks Hospital, Summit, New Jersey.

INSIDE



NEWS

Briefly ...

Pot is faster

SYDNEY — It takes only a few puffs of a marijuana cigarette to produce impairment equal to that caused by 0.05% blood alcohol concentration. So says a study reported in *Connexions* on the relative effects of marijuana and alcohol on driving skills. And, while it takes 40 minutes for alcohol consumption gradually to decrease motor skills, it takes only five minutes for marijuana to take effect, says the Sydney University study. Performance in steadiness, coordination, reaction, and logic were tested in 240 volunteers.

Smoke-free office

BOSTON — A Massachusetts state employee has won the right to work in a smoke-free office following a two-year battle with her employer. The welfare caseworker filed suit against the state, complaining of dizziness, irritated throat, and watery eyes from the cigarettes of 18 smoking co-workers. In an out-of-court settlement, the department has agreed to shift the worker and other non-smokers to a separate office, reports *Associated Press*.

Smuggler's ruse

LONDON — It's cocaine in the wet season and crocodiles in the dry season," the *London Sunday Times* quotes one South American wildlife dealer as saying. Thus, Britain is joining other European nations to probe cooperation between drug smugglers and illegal wildlife shippers. One ruse is to send cocaine with shipments of live parrots. Some of the birds are killed, stuffed with the drug, and appear to have died in transit. Peddlers are also exploiting the lucrative market in crocodile skins to French and Italian leather industries. The skins are normally dusted with a white preservative. In some cases, the powder was found to be cocaine, which was later retrieved with a vacuum cleaner.

Drugs cut drink sales

TORONTO — The chairman of the Ontario Liquor Control Board blames the illicit sale of marijuana, cocaine, and heroin, for the decline in beer and liquor sales in recent years. Jack Ackroyd, former Metro Toronto police chief, told a sales and advertising club luncheon here that sales of illicit drugs are a "big reason" for the drop in alcoholic beverage sales. He added that the slack economy, awareness of health, and concern about drinking and driving are also taking their toll on beverage sales.

Move over milk

WASHINGTON — United States residents are drinking more alcoholic beverages than milk, says the US department of agriculture. Milk accounted for 20.3% of the total drinks consumed in 1982 but beer (18.32%), combined with wine and liquor (3.1%), brought the total for alcoholic beverages to 21.4%. Soft drinks were still the most popular beverage in the US, with per capita consumption set at 39.5 gallons in the same year, according to the *Monday Morning Report*.

Court rules that prescribing is not trafficking

Charges dropped against BC doctor

By Tim Padmore

VANCOUVER — A second court decision has further weakened the cases against seven doctors charged in May 1984 with a variety of drug-trafficking offences (**The Journal**, Nov, July, 1984).

Last December, a provincial court judge declared null a charge of "being a practitioner unlawfully administering a controlled drug" against Dr Anthony Otto.

Earlier, the Saskatchewan Court of Appeal, overturning a lower court decision, ruled that prescribing does not constitute trafficking under the Narcotic Control Act.

Following the Saskatchewan decision, the Crown stayed all the trafficking charges that had been laid against the British Columbia doctors under that Act.

However, other charges had been laid under the Food and Drugs Act. (Different drugs are covered under different Acts. For example, Talwin [pentazocine] is a controlled drug under the Food and Drugs Act, while Fiorinal C [ASA, codeine, caffeine, butalbital] is defined as a narcotic under the Narcotic Control Act.)

The Crown also stayed charges of trafficking laid under the Food and Drugs Act. However, that Act also provides for regulations that define as an offence the "administration" of a drug not required for treatment to someone not a patient.

The December decision effectively dismissed administering charges laid against Dr Otto under the act.

Judge Robert Lemiski ruled that the offence was "not known in law."

As **The Journal** went to press, only two doctors had been committed for trial on trafficking and administering charges. They were committed for trial prior to the latest court decisions.

Heroin — 'a question for every physician'

(from page 1)

the country, said Dr Cook. Sixty thousand copies have been distributed.

The monograph, which Dr Cook says has been highly praised both in Canada and internationally, does not mention heroin, of course, as it was distributed last fall.

Will physicians still appreciate the monograph's intentions when heroin becomes widely available?

Dr Cook: "That's a question for every physician to answer. When the day comes that heroin is available, then each physician will have to make up his own mind. You will find that some will say 'no, I don't think heroin is any good, I prefer the others,' and some will say 'it seems that heroin has some advantages.' "

The re-introduction of heroin has also confused the public, who, through media reports, perceive the issue as a legislative rather than administrative move.

Jean Sattar, information officer for the Health Protection Branch, Health and Welfare, told **The Journal**: "It has been impossible to use heroin for the terminally ill simply because there wasn't any. If a physician had kept a stock of heroin since 1954 in his back drawer, he would be perfectly free to use it.

"What was stopped (Jan 1, 1955) was the signing of importation permits to import pharmaceutical-grade heroin. What we are proposing to do now is sign those importation permits which are jointly co-signed by the minister of Health and Welfare and the director of the Bureau of Dangerous Drugs."

WHO studies pain control

GENEVA — A three-step "analgesie ladder" for pain control in eancer patients, developed by the World Health Organization (WHO), has proven sueeessful in a Japanese trial.

The "analgesic ladder" calls for preseribing drugs at regular intervals, increasing in strength from non-narcoties (aspirin [ASA]) to mild narcoties (eodeine) and then strong narcoties (morphine) until the patient is pain-free.

The guidelines were developed by the WHO to teach non-pain specialists how to control caneer pain by using a few potent drugs well.

Dr Fumikazu Takeda of the Saitama Cancer Centre near Tokyo says 87% of patients in a 1983-84 study reported complete relief from pain, 9% "aeceptable relief," and the remaining 4% "partial relief."

New technologies boosting alcohol research

(from page 1)

The enhancement and increased quality of research — which serve also to bring in new researchers — have resulted in an increase in knowledge, he continued. "We know a lot more about the effects of alcohol on human and non-human organisms than we knew a while ago, and we will know a lot more in the next few years."

Dr Niven predicted that within the next five years "we will have some of the answers to some of the problems that now we don't have the answers to. We have glimmers, but don't have the answers, as to exactly what it is about drinking by some women during pregnancy that causes them to have deformed babies. I think we will know the answer to that by 1990.

"I think we will know in the next half-decade, with a lot more precision, exactly which children of alcoholic parents are at risk of developing alcoholism, which of these children may be at risk of developing certain alcohol-related medical problems if they choose to drink, or continue to drink, or drink heavily."

Another exciting aspect of research, which is making a major contribution to general health, has been the development of new technologies completely outside the alcoholism field but which, if used in the understanding of the effects of alcohol, have major potential.

'We will know a lot more in the next few years . . .'

"Already such things as the PET scan have enabled us to understand better some aspects of working with Korsakoff's syndrome," Dr Niven said. "We know now, rather dramatically, and can picture (with the scans) rather dramatically, some of the differences between the intellectual problems people with Korsakoff's syndrome have, compared, for example, with those people with Alzheimer's (disease) have."

With PET scans, scientists at the NIAAA have demonstrated the differences in brain pathology between the two conditions.

A critical trend in the burgeoning of research in the alcohol field has been the attracting of researchers to the field. "We have researchers coming in now who are sometimes established researchers in other fields, and who are getting interested in studying the effects of alcohol," he added.

The major contribution to that development has been the explosion of new knowledge, "and it is turning on some scientists, opening up ideas they had not previously thought about, and which they want to explore."

Related to this, Dr Niven believes, has been a decrease in the stigma associated with being a researcher in the alcoholism field.

"A lot of people haven't appreciated (the fact that) in research circles there has been some stigma attached to being an alcohol researcher. It has not been, and in some circles still isn't, looked upon as being an ideal way for a scientist to spend his or her career. That is being changed, and we will all be better off for it," he said.

The second trend has been a tremendous increase in the quantity of research done. Although the NIAAA in recent years has been able to fund more research, it is still impossible to keep pace with demand.

Even in the midst of fiscal constraints, Dr Niven is confident there will be money for alcohol research, and there will be growth. "But whether this growth will, indeed, come close to meeting the demand that exists for new knowledge about alcohol, and whether we meet that, is highly questionable, I think."

The third trend, and it affects everyone who does alcohol research, is the tremendous increase in public knowledge, and among some professional groups, of the extent of alcohol problems. "This awareness, in fact, is even beginning to develop around the world as there are people in many countries who had previously not thought about alcohol as being a problem in their country, who are now beginning to look at it in that light," Dr Niven said.

In the long haul, this will be good for those in the field. But, at the same time, "it is translated into increased demand for solutions."

Dr Niven said one lesson he learned quickly on arriving in Washington to take over the NIAAA (**The Journal**, Oct, 1983), "is that politicians and bureaucrats in many respects don't like to say 'no' when they don't know answers to problems. That gets us into trouble sometimes because it is one of the things, I think, which leads us to try to give answers, or suggest solutions, when we are not very confident they are the right answers or the right solutions.

"It leads us sometimes — and I think this can indeed be a problem throughout our field and not just in government — into not looking critically at some of the statements we make, some of the services we provide, some of the conclusions we reach.

"It may be a thing that gets us into a lot of trouble, because if we are not looking for the answers, we are then left to chance as to whether or not we stumble upon them. And we can be subject to criticism if we think we know the answers, and we turn out to be wrong."

Dr Niven said that in the next few years the major pressure on alcohol research, treatment, prevention, education, "in fact everything about alcohol, in terms of health aspects of alcohol, will be the tremendous pressures (in the US) to contain health care costs. This is producing tremendous scrutiny of all aspects of medical care, and this is going to include research."

The focus by private insurers will be on straight value for money, and there is an increasing reluctance by insurers to pay for much alcoholism treatment.

"There is a decreasing willingness to pay Cadillac prices for Volkswagen products," Dr Niven said, "and some will not pay for Cadillac quality, even if they get that, if they think a Volkswagen is going to get them there. If they can get the same benefit for an out-patient program as an in-patient program, they are not going to pay for an in-patient program.

"If you can't demonstrate the differences in product, they are going to purchase what they consider the best value."

NEWS

UK health experts demand coordinated alcohol action

By Alan Massam

LONDON — The British government is facing a growing chorus of discontent from health educators who want to see a coordinated policy to deal with alcohol abuse.

This became clear in a well-timed conference prior to festivities at Christmas 1984 when the British Medical Association and the Institute of Alcohol Studies combined forces.

Their symposium, Alcohol: Preventing the Harm, opened with a speech by Parliamentary Secretary for Health, John Patten, in which he reiterated the government's view that "the key for preventing misuse is for individuals to recognize and accept responsibility for their own health."

"Where the government and other agencies do act, they can, in general, do so effectively only with the broad consent of the public," he said.

Mr Patten's explanation produced a restless response from his audience of health educators and clinicians, but parliamentary business prevented him from staying to deal with their questions.

The message came over loud and clear, however, from the director of the Institute of Alcohol Studies, Derek Rutherford, who quoted several authoritative reports emphasizing the need for fiscal controls on alcohol consumption. Ten years had elapsed since the reports were published, he said, yet Britain was no nearer producing a coordinated national policy on alcohol.

Mr Rutherford was particularly concerned about the government's failure to publish the 1979 report of its own Central Policy Review Staff (the so-called Think Tank) when pirate publication elsewhere had suggested that it recommended measures to prevent per capita consumption rising any further. (**The Journal**, May, 1983).

"The fate of that report is a salutory reminder of the political influence and power of alcohol on society," Mr Rutherford said.

"Reports which apparently favor consumption and easy availability have no difficulty in being acceptable to the British government — unlike reports which seek to curtail consumption.

"The British public has been denied the opportunity to read the most important report on alcohol and alcohol problems produced in the UK for many years. Such action must question the commitment of the present government to the implementation of control policies which would make an impact on consumption and harm."

Mr Rutherford explained that there were 16 government departments concerned with alcohol or alcohol abuse and there was no mechanism to ensure that they were all pulling in the same direction.

Support for the main theme came from David Player, director of the Health Education Council, who told the conference that health education programs, however well researched and improved, could achieve very little in isolation. Experience around the world has shown that alcohol education programs, acting alone and against the social and political tide, showed little promise of success in the long term.

An educational project might be held up to prove that something was being done about the problem, so that action on other more controversial areas could be put off for another day.

Dr Player believed that health education should fall into place as just one component of a comprehensive policy of measures to reduce alcohol consumption and consequent harm. Such a policy would encompass: fiscal measures linking alcohol prices with the rate of inflation; access control to freeze the number of sales outlets; legal measures to ensure that penalties for abuse causing public harm were properly enforced, and curbs on the promotion of alcohol.

Dr Player, whose budget for health education is seen by many as modest, said alcohol promotion ran right through British society and was almost impossible to ignore.

Apart from the £100 million (Cdn $148 million) spent annually on direct advertising there were about 100 sporting events sponsored by drink firms, plus arts and other prestige events. Whiskey firms even ran sporting events for children.

"Through such diverse activities, alcohol is linked with glamor, sex, sport, and everything else that is attractive to the young," Dr Player said. This is despite the fact that there are advertising codes expressly forbidding it.

"It is this deliberate attempt to influence children and young people which blows a hole through the argument that alcohol promotion only seeks to persuade drinkers to switch brands."

Dr Player added: "There is a call for more specific goals to be formulated with quantified targets set. . . . Bodies like the Royal College of Psychiatrists suggest an initial goal of holding down to their present levels measures such as national per capita alcohol consumption together with the available indices of alcohol-related harm, that is, stopping any further escalation of the problem.

"A second stage would aim to reduce alcohol consumption and harm by agreed percentages over the next decade. What a realistic reduction would be is still under discussion, but the setting of this target is a priority task for all those working in the alcohol field."

Prof Robert Kendell, of the department of psychiatry, Royal Edinburgh Hospital, told the conference that in the absence of Draconian controls, price of alcoholic beverages relative to disposable income was the most important determinant of per capita consumption. The fall in this ratio in the UK between 1950 and the mid-1970s was the main cause of the doubling of per capita consumption that took place during that period, he said.

Kendell: absence of controls

On at least two occasions in the past (1751 and 1915) the British government took effective action to reduce alcohol consumption.

"The same could be done again, but only if both the government and the electorate were convinced that the medical, economic, and social ill-effects of current consumption levels, which are less than those of many other European countries, outweighed the pleasures and economic benefits," Prof Kendell said.

Prof Alan Maynard of the Centre for Health Economics, University of York, told the conference that estimates of the social costs of alcohol abuse were incomplete because of poor data, but the best "guesstimate" would certainly produce a figure of more than £1,600 million annually for the UK.

An alternative measure was to estimate the number of life-years foregone as a result of premature deaths associated with alcohol use. These deaths included cirrhosis and accidents associated with alcohol. In 1982, the estimate was between 5,099 and 8,073 premature deaths resulting in between 118,065 and 190,267 years lost.

Prof Maynard added that, despite the poor data, it was clear that the burden placed on society by alcohol use was considerable.

Prof Sir John Crofton, Chairman of the Scottish Health Education Coordinating Committee, said he hoped the conference would help to foster a climate in which people in many walks of life would build up a driving enthusiasm "to do something effective about this tragic problem."

Modern-day tale no rival for classics

By Wayne Howell

John Zachary De Lorean looks like a Greek. Not a Zorba-type Greek, a Homeric-type Greek — part mortal, part god. And he lived like one. For just as Zeus transmogrified himself into a swan — the better to seduce the unsuspecting Leda — so too did De Lorean transform himself, with a little help from plastic surgeons, into a seducer of the Hollywood variety of nymph.

And, just as the man-gods of Aeschylus and Sophocles came tumbling down, did not he too reach his nadir because of that human quality that is the heart and soul of Greek Tragedy: hubris. Hubris — the overweening pride that was the nemesis of Phaëton, and a long line of mortals stretching from Ozymandias to Napoleon.

Well, all I can say is that the tragic heroes of literature had more of a sense of occasion than John De Lorean. Take, for instance, Dr Faustus of Wittenberg. Like De Lorean, he too was caught in a "sting" operation. But in his case the sting was not mounted by FBI agents, it was mounted by the Devil himself.

As Christopher Marlowe describes the bust, it goes like this:

Faust: Ah, my God, I would weep, but the Devil draws in my tears! Gush forth blood instead of tears! Yea, life and soul! Oh, he stays my tongue! I would lift up my hands, but see, they hold them, they hold them!
All: Who, Faustus?
Faust: Lucifer and Mephistopheles . . . I writ them a bill with mine own blood: the date is expired.

Well, when they came to slap the cuffs on John De Lorean, it didn't quite go like that — no references to tears and blood and souls and that kind of thing. The fall of this Titan was decidedly inarticulate, as the FBI tapes demonstrate:

[Enter J.G. West and J. Aguilar]
Special Agent Jerry G. West: Hi John.
De Lorean: Hi.
West: Jerry West, I'm with the FBI. You're under arrest for narcotics violation. This is José Aguilar. He's with DEA (US Drug Enforcement Administration). Could you stand up please?
De Lorean: All right. I don't understand it.
West: Okay, turn around. [Handcuffs him.]
De Lorean: Yeah.
West: Okay, you wanna sit back down?
De Lorean: It's pretty hard [because of the handcuffs].
West: All right, just sit on the edge.
De Lorean: Fine.
West: No, sit down on the edge. John, I'm gonna advise you of your rights. . . .

'Yeah' and 'fine' seem vaguely unsatisfying comments from someone who at one time bestrode the automotive world like a colossus, a hero brought to grief because he could not bear to see the gull-winged dream-chariot that bore his name die. But these are modern times in which we live, and I guess it is unrealistic to expect De Lorean to have carried on like Sophocles says King Oedipus carried on *("Woe! Woe! Woe! Woe! all cometh clear at last. O light, may I ne'er look on thee again")* prior to striking out his own eyes by way of penance. I guess it is sufficient that De Lorean became a born-again Christian under the tutelage of ex-Watergater Chuck ("I'd drive over my own mother") Colson.

"I am determined to prove a villain . . . plots have I laid, inductions dangerous," Shakespeare quotes the Duke of Gloucester as saying, before he spells out his plan to become King Richard III, a plan he puts into gear with admirable dispatch. But then communications were simpler in the days before Ma Bell.

Nowadays, when a former drug smuggler turned DEA informer tries to lay a few dangerous inductions on a desperate industrialist he can run into technical problems, as this excerpt from the De Lorean tapes demonstrates:

Woman: Hold on [pause]. Mr Hoffman?
Hoffman: Yes.
Woman: Can you hold on 'cause I think he'll (De Lorean) be with you in a minute if you can hold.
Hoffman: Sure, I'll be happy to hold.
Woman: Okay, thank you. Are you still there?
Hoffman: I'm here.
Woman: There's something wrong with my phone. The light's not working. I'm afraid I'm gonna . . . [laughs].
Hoffman: Oh.
Woman: [unintelligible] in the phone booth. I don't wanna do that.
Hoffman: If I lose you. I'll just call back.
Woman: Okay, but . . . .
Hoffman: I'll replace the call.
Woman: I'm gonna hopefully be putting you on hold.
Hoffman: Okay [pause].
Woman: De Lorean Motor Company
Hoffman: Hi, I was holding, uh, for . . . .
Woman: Mr Hoffman?
Hoffman: Yeah?
Woman: Uh, ha-ha, yes.
Hoffman: I did. All of a sudden you just weren't there.
Woman: Hold on, okay?
Hoffman: All right.
Woman: I was afraid of that [laughs].
Hoffman: Yeah [laughs].
Woman: Hold on. I'm gonna switch you over to another line and not this one [unintelligible] okay?
Hoffman: Okay.
Woman: One moment.
Hoffman: Great.
Woman: Are you there?

And so on, and so forth . . .

Unlike the Duke of Gloucester, who could pursue his nefarious plots by way of whispered conversations in palace corridors, the man who told the FBI "I'm going to get John De Lorean for you guys" had to deal with Lily Tomlin's Ernestine on the switchboard.

But it is not just modern-day protagonists like De Lorean or Richard Nixon (he had his tapes too) that fail to satisfy. Choruses just aren't what they used to be either. For instance, as Dr Faustus is carried down to hell, Marlowe's chorus puts things in proper perspective:

Chorus: Cut is the branch that might have grown full straight,
And burned is Apollo's laurel bough.
That sometimes grew within this learned man.
Faustus is gone; regard his hellish fall,
Whose fiendful fortune may exhort the wise.

So too does the Sophoclean chorus that brings down the curtain of Antigone put things in proper perspective:

Chorus: 'Tis best in word or deed,
To shun unholy pride;
Great words of boasting bring great punishments. . . .

The De Lorean chorus was not so much interested in weighty moralizing as in discussing which designer-dresses De Lorean's wife Christina would choose to wear to his trial and what effects the outfits might have on the jury.

(De Lorean was acquitted on a charge of conspiring to import cocaine to the US.)

NEWS

RESEARCH UPDATE

THC and brain atrophy in monkeys

Long-term ingestion of delta-9-tetrahydrocannabinol (THC) has been shown to atrophy part of the brain of rhesus monkeys. John McGahan, MD, Arthur Dublin, MD, and Ethel Sassenrath, PhD, of the University of California, Davis, performed high-resolution computer tomography (CT) scanning of the brain on three groups of monkeys. One group acted as a control, a second group was given 2.4 milligrams per kilogram per day of orally administered THC during an average period of 7½ months, and a third group had been given a similar daily dose of THC during a five-year period. The drug dosage was considered to be equivalent to smoking one marijuana cigarette daily. None of the monkeys had received the drug for one year prior to CT scanning. The CT measurements conducted in the study demonstrated enlargement of the ventricles which suggests atrophy of the head of the caudate nucleus and the frontal portion of the brain of the monkeys who had received THC for five years. This finding was statistically significant when compared with those for both the short-term subjects and the drug-free controls. While the three researchers stated the results can not be directly applicable to humans because of potential species variation, they believe they have shown macroscopic cerebral effects of the drug when ingested over a long term by monkeys.

American Journal of Diseases of Children, Dec 1984, v.138:1109-1112

Television-induced seizures in alcoholics

Television can induce seizures in alcoholics. This surprising discovery has been made by three Belgian researchers who reported three cases of chronic alcoholics who, during a period of abstinence, had a *grand mal* seizure while watching or adjusting a television set. The three men, aged 26, 31, and 40 years, had all stopped drinking for one or two days prior to their seizures. The researchers from the department of neurology, Akademisch Ziekenhuis, Vrije Universiteit Brussel, Brussels, noted that such tension-induced seizures usually occur in patients with photosensitive epilepsy. They said that while the reported cases may simply have been coincidence, "it is tempting to assume that their seizures were television-induced," because of the heightened photo-sensitivity observed in the electroencephalograms of patients after alcohol withdrawal. They suggest that photic stimulation in the patients, brought about by television, might exacerbate a latent dopaminergic (dopamine acts as a neurotransmitter in the central nervous system) deficiency in the visual cortex as a result of alcohol withdrawal and lead to a seizure. The researchers conclude that if a patient presents with a television-induced seizure the possibility of alcoholism should be examined because management would be completely different from that of photo-sensitive epilepsy.

British Medical Journal, Nov 3, 1984, v.289:1191-1192

Quitters' lung function improves

A detailed study of lung function in a group of Los Angeles adults confirms that smoking cessation improves respiratory function and prevents progression of respiratory symptoms associated with tobacco use. Residents between 25 and 64 years of age in three communities in the Los Angeles area completed a detailed respiratory questionnaire and had measurements taken twice, five years apart, of forced expired volumes and flow rates, closing volume, and closing capacity. The 2,401 subjects fell into four smoking categories: non-smokers, former smokers, continuing smokers, and those who quit between the times the tests were done. Smoking cessation was seen to lead to a significant improvement in symptoms of cough, wheeze, and phlegm production, and to significantly less decline in indices of small airway function when compared to the measurements of those who continued to smoke. Improvement in lung function was seen to be most significant in quitters who had not yet developed significant chronic airway obstruction, and the differences could not be attributed to differences in baseline lung function or quantity of tobacco smoked, or even the time at which the quitters ceased to smoke during the five-year period.

American Review of Respiratory Disease, Nov 1984, v.130:707-715

Hepatitis drug treatment studied

Evaluation of two types of drugs for treatment of moderate or severe alcoholic hepatitis has yielded mixed results although one of the drugs — oxandrolone — was seen to have a long-term beneficial effect. A total of 132 patients with moderate disease and 131 with severe disease were studied at six Veterans Administration Medical Centers across the United States. The patients were divided into three groups and received either placebo or 30 days of treatment with either a glucocorticosteroid (prednisolone) or an anabolic steroid (oxandrolone) both of which have been reported to have beneficial effects. After treatment, patients were evaluated monthly. At the end of the treatment period, neither of the drugs had improved mortality rates when compared with the placebo group, and 13% of the moderately ill patients and 29% of the severely ill patients had died. However, when the patients who had received oxandrolone therapy were followed for more than 300 days, their survival rate was seen to improve, especially patients with moderate disease. For those who survived one or two months after the start of treatment, the conditional six-month death rate was 3.5% after oxandrolone, compared to 19% to 20% after placebo, with prednisolone therapy showing no beneficial long-term effect.

New England Journal of Medicine, Dec 6, 1984, v.311:1464-1470

Pat Rich

UK boosts anti-drug fund in bid to stem abuse tide

By Alan Massam

LONDON — The government has earmarked a further £2 million to its growing financial commitment to the problem of drug abuse — bringing the total government contribution to prevention and treatment to £12 million (Cdn $17.8 million).

Health Minister Kenneth Clarke said the new money would be used to finance a prevention campaign. He added: "The department of health and social security is responsible for the treatment and rehabilitation of drug addicts. We have to accept that they are not always the most popular and responsible of patients. Nor is there any guarantee of success through any method of treatment.

"Perhaps a third of addicts stay off the habit after treatment. But we have to do everything we can. We believe that the best hope lies in tackling the problem at the local level."

Mr Clarke added that more than 80 projects dealing with drug abuse have now been approved by his department in a three-year period and costing about £5 million. They include a street-based walk-in clinic for young drug users in Cambridge and a comprehensive pilot scheme for the treatment and rehabilitation of drug users in northwest England.

In addition, regional health authorities are asked to tell the department what they are doing to combat drug abuse, and professional bodies are being asked if they are implementing the training recommendations of the Advisory Council on Drug Misuse.

Research is also being funded to investigate why addicts relapse and how drugs affect adolescents and young adults.

Drunk-driving campaign under fire

Moderation message slammed

By Alan Massam

LONDON — Doctors and health educators are expecting 1984 Christmas road accident statistics here to show increased deaths and injuries. The forecast follows in the wake of the miners' strike which left many roads without police patrols, and the view of many experts that the department of transport's current campaign to restrict drinking and driving has been ineffective.

The campaign took the motto "Stay Low Or You Might Live To Regret It" instead of "Never Drive and Drink" which was introduced prior to Christmas 1983.

An outspoken critic of the "Stay Low" campaign was Douglas Acres, a family physician and chairman of the Magistrates Association. Dr Acres said the campaign slogan appeared to condone drinking and driving, although it is known that even a small amount of alcohol could affect a driver's reaction.

Also critical of the department's policy change were the British Medical Association and spokesmen for police and motoring organizations.

And, a member of parliament, Teddy Taylor, asked the minister of transport what discussions took place between his department and the drinks industry "on the issue of the participation of the industry in campaigns designed to curb the consumption of alcohol by drivers."

A spokesman for the Institute for Alcohol Studies said later that the minister's reply had been non-committal. "We suspect that the decision to use the "Stay Low" motto is part of a general campaign by the drinks industry to promote moderate drinking," he said.

Pediatricians have anti-smoke role

By Jean McCann

CLEVELAND — A pulmonary specialist says he is appalled that some doctors who treat children don't ask them if they smoke.

"The fact is that most people start smoking in the pediatric age range," said David Sachs, MD, assistant professor of medicine at Case Western Reserve University here.

"If I were a pediatrician, I would want to ask a child of eight or nine 'do you smoke?' " But "most of them would probably look at me cross-eyed and say 'of course not.' And then I would say 'that's really terrific. You are a smart kid because smoking just wouldn't be good for you. I'm glad you are not smoking.' So you can reinforce that.

"On the other hand, if the kid is smoking . . . that gives the pediatrician an opportunity to intervene."

Dr Sachs told The Journal his concern about the failure of doctors to help stop smoking early followed a survey he did of smoking behavior at a meeting of the American Thoracic Society. He asked the physicians attending about advice offered patients.

"I had this pile of answers of about 21 pediatricians, and when I started coding the answers I realized they essentially all were blank. They scrawled across the part of the questionnaire about smoking advice given to patients 'not applicable.' Some of them even wrote 'not applicable to my practice.' That's when I started scratching my head, realizing that most people start smoking when they're (less than) 17 years of age."

Dr Sachs said also that when children do smoke it's generally in response to peer pressure so that doctors should discuss with parents how the child can change his peer group. "Adolescence is a very trying time for kids and, if this is an issue they haven't already worked out in their minds, peer acceptance can sway them."

Seminar probes drug dangers for women doctors

TORONTO — Substance abuse and occupational hazards will be one workshop topic at a symposium here this month aimed at assisting women medical students deal with the stress of training and practice.

Murmurs of the Heart: Issues for Women in Medical Training is sponsored by the Women in Medicine Support Group at the University of Toronto. The two-day symposium (February 8-9) marks the 100th anniversary year of women at the University.

Representatives from the Addiction Research Foundation and general practitioners will guide a discussion about dangers of substance abuse among doctors and such occupational hazards as exposure to AIDS and hepatitis.

'What appears in the graphs is very much a first stab at describing recent trends in research on some of the more popular psychotropic drugs.'

Microcomputers

By Richard Gilbert

I bought a microcomputer in mid-1982. It transformed the way I prepare for and write these columns and the other academic and near-academic work I do. The computer makes it possible for me to be a full-time politician and maintain a toehold in academic life.

My setup, dating from the early rather than the mid-1980s, is antiquated in terms of what is advertised today. It is based on the horse-and-buggy CP/M operating system, has less than 60 kilobytes of usable memory, no graphics to speak of, and disk drives of miserably small capacity. But, as well as low cost (about a quarter that of an IBM PC), it provides a most important advantage for the private user of few financial means — access to a mountain of free software in the public domain, available for almost every purpose.

Machine dependence

A measure of my dependence on the machine is that I recently bought a used model as a back-up — at an alarmingly cheap price. I also have printers both for fast and for pleasing output — they are the trickiest part of the game — and the essential modem for linking the computer via telephone lines to the world outside my home.

I use the computer mostly as a word processor. You've probably heard it before: once you start using a word processor you'll never want to go back to typing or writing things out by hand. I write in a messy way, often changing things around. My typing is proficient, but I could never create happily on the typewriter because of the clatter and the tedium of inserting, deleting, and re-ordering words, a tedium greater than the tedium of handwriting.

Now, words fly in and out of and around the electronic page with silent ease. There are handy bonuses too, like proofreading and indexing programs, automatic word counts, reformatting at the touch of a key, and the ability to recycle used text seamlessly into new material.

Real time-savers

The joy of word-processing alone would justify the cost of the computer, but two other facilities are the real time-savers.

One is the database program that organizes my collection of journal articles and other sources. In the days before the computer, all my attempts to bring order to thousands of interesting articles failed. The various systems I tried were either so simple as to be virtually useless or so complex as to be a massive chore to maintain.

A computer-based system for organizing sources combines usefulness with relative ease of maintenance. It is still a chore to keep current, but the advantages stimulate diligence. I can now find in a few tens of seconds the half-dozen articles I have on, for example, cigarette use and hand tremor, or those I hold by a particular author. I am writing a book on caffeine just now and think back with astonishment at how much sweat it would have taken to have kept 1,300 or so sources in order without the computer.

The other time-saver costs money to use but is worth every penny. It is the ability my computer gives me to make use of commercial databases. Mostly I use a service called Knowledge-Index (KI), which is the way in which poorer people can use some of the facilities of Dialog Information Services of Palo Alto, California.

The regular Dialog service contains hundreds of databases. It is available almost 24 hours a day, and costs as much as $5 (US) a minute to use. KI can be used only between 6 pm and 5 am and on weekends, but costs just 40 cents (US) a minute, including telephone charges between Toronto and Palo Alto.

Through KI, I can "access" some 30 databases. They include, for example, the LEGAL RESOURCE INDEX, which provides "complete access to key law and law-related literature" since 1980: NEWSEARCH, in which are indexed all articles published in three major US daily newspapers and 370 US magazines since the beginning of the current or the previous month; and BOOKS IN PRINT, which lists all books in print in the US.

I use MEDLINE most often. It is the electronic version of Index Medicus, produced by the US National Library of Medicine. MEDLINE contains most of the four million items published in the medical and near-medical literature since 1966. I also used PSYCHINFO, produced by the American Psychological Association. It covers "the world's literature in psychology and related behavioral and social sciences such as psychiatry, sociology, anthropology, education, pharmacology, and linguistics."

The key to using the KI databases or any others inexpensively is to plan your search. I make much use of a public domain program that allows me to issue lengthy instructions to the computer with single keystrokes, thus avoiding error and saving valuable on-line time.

For example, to search for articles on caffeine and human pregnancy, I define a keyboard character (say lower-case "p") as "FIND (CAFFEINE OR COFFEE OR TEA) AND (PY=1983 OR PY=1984) AND PREGNAN? AND HUMAN." This means "list in my work space the articles published since January 1983 that have somewhere in their titles, abstracts, or descriptors the following combinations of words: caffeine/coffee/tea plus pregnant/pregnancy/pregnancies plus human." (Note the use of the "?" to allow searching for variations on a given stem.)

Expensive listing

A few seconds after pressing "p," I will be told there are 27 such articles. Then, with a further instruction, I can list some or all of them on my computer screen in one of three ways: (i) titles only, (ii) authors and sources too, and (iii) abstracts and descriptors as well. Listing is the most expensive part of the process. It is done judiciously. I save every part of the dialogue with the KI computer on a floppy disk for later editing and printing out.

A search during which I would list all 27 titles and eventually five of the abstracts could cost about $4 (US). It would save many hours of library work, and likely also turn up sources that a visit to the library would miss. I have to go to a library to read the articles in full, but my time there is used efficiently.

Many academic libraries, including the one at the Addiction Research Foundation, (ARF)are subscribers to the Dialog service. ARF librarians will do a search for you with great skill, but there are two disadvantages. One is the cost — MEDLINE is 58 cents (US) a minute through the regular Dialog service, PSYCHINFO is 92 cents, NEWSEARCH is $2 — not so much a problem perhaps if your institution is paying. The other is that you lose the advantage of interacting with the database yourself. Librarians might not be able to recognize a wild-goose chase as early as you can. Worse, they might miss a clue to a useful and unsuspected area of research.

A temptation when using an inexpensive electronic database is to dribble away money engaging in *metaresearch*, ie, research about research. Metaresearch doesn't tell you much about medical and scientific phenomena. It may reveal a lot about the behavior of researchers.

A piece of metaresearch I conducted recently concerned trends in drug research since 1966, which is as far back as MEDLINE goes. The results of this work appear in the graphs on this page. (The graphs, incidentally, were generated by computer, and then traced over to enhance their appearance. They are set out in two columns only to improve readability.)

What appears in the graphs is very much a first stab at describing recent trends in research on some of the more popular psychotropic drugs. The graph for each drug or drug class raises many questions about the trends it depicts and about its relation to the other graphs.

Questions

Why, for example, did the rate of mentioning ethanol increase by a factor of more than seven during the 19 years? Does this reflect a real growth in interest in the drug, a greater use of ethanol for incidental purposes, or increased popularity of the word ethanol among researchers?

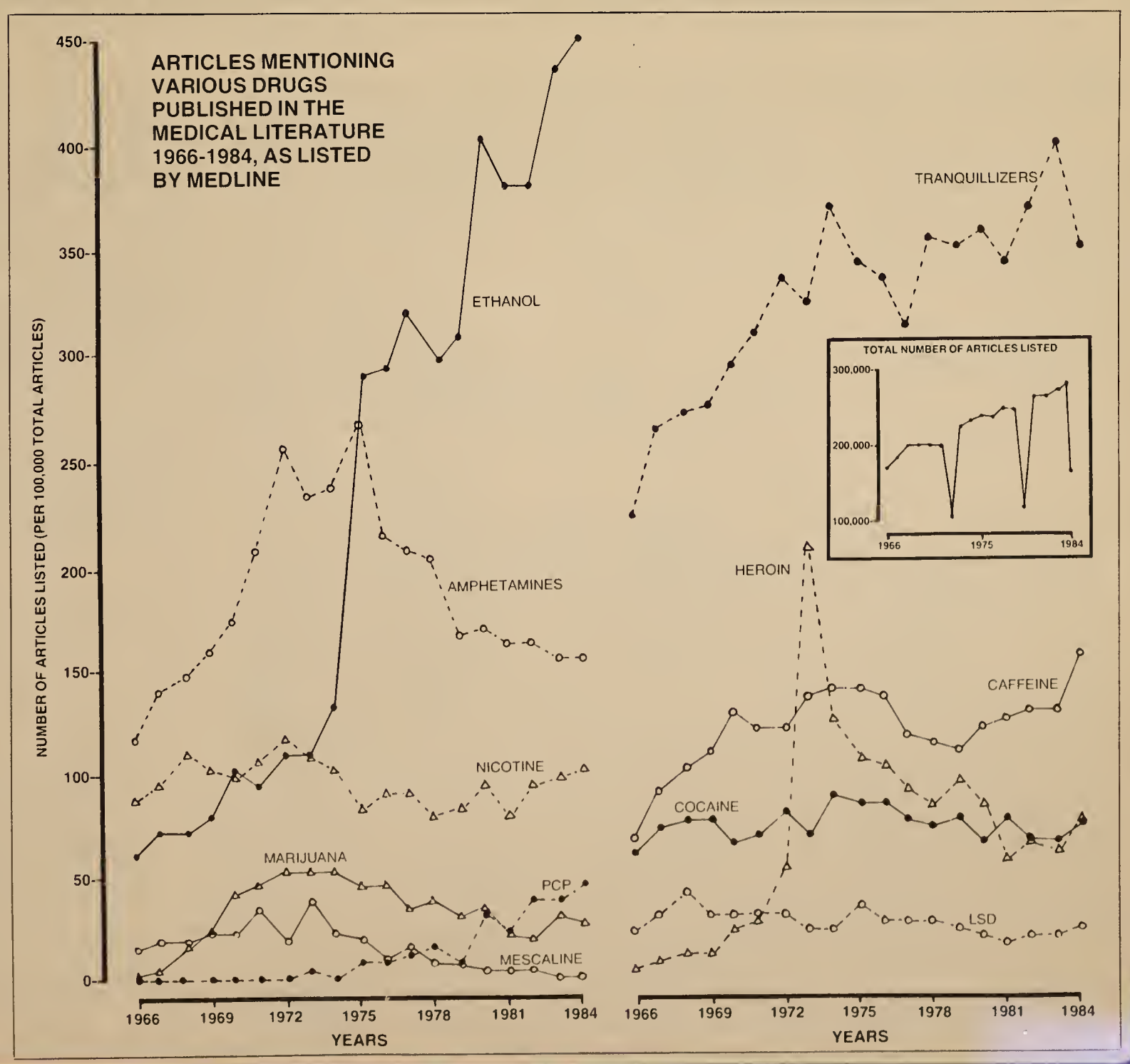
What accounts for the steady increase in mentions of tranquillizers (both major and minor), while mentions of amphetamines have waxed and waned, and those for nicotine have shown amazing steadiness throughout the period. Would a search for ("CIGAR? OR TOBACCO") have revealed the same constancy?

How can the relatively low rate of mentions of marijuana be explained? Would I have achieved a more realistic picture of medical concern about this drug if I had used "CANNABI?" rather than "MARI?" as a search term?

Similarly, what caused the dramatic peak in mentions of heroin in articles published in 1973? Would the graph of "OPIATE?" mentions be very different?

How much of the interest in these and other drugs is determined by popular concern — which is undoubtedly behind, for example, both the decline in mentions of mescaline and the increase in mentions of phencyclidine (PCP)? How much is determined by medical or scientific imperative? The graphs here provide little clue. Searches of the MAGAZINE INDEX and the NATIONAL NEWSPAPER INDEX databases (both available in KI) would indicate trends in mentions of these drugs in 370 popular magazines from 1976 and in three newspapers from 1979. Correlating these with mentions in the medical literature might provide hints of the extent to which research is driven by public alarm, and vice versa.

I have answers to none of these questions, nor to why MEDLINE listed relatively few articles in 1972 and 1979 — as shown in the box found among the graphs. The next time I am able to invest in an hour or two on-line with KI I might take a shot at finding some of them out.



DRINKING AND DRIVING

The stakeholders are many: Simpson

Drunk-driving issue demands patience, resolve

By Terri Etherington

TORONTO — The solution to the alcohol crash problem may not be simple, but it should be "obvious and straightforward," says a Canadian traffic safety expert.

Eliminate the overlap between drinking and driving, says Herb Simpson, PhD, executive director of the Traffic Injury Research Foundation, Ottawa.

"That time-worn admonition, 'if you drive don't drink, if you drink don't drive,' is the solution," he told a drinking and driving symposium here.

But, he said, "literally hundreds of ways to keep these activities separate have been tried in the past several decades. The remarkable persistence of the alcohol crash problem in the face of such efforts suggests that simple solutions may be illusory."

On the one hand, almost any intervention seems to be considered appropriate, said Dr Simpson. Solutions being tried range from seatbelt legislation and increased safety of roadways, through increased legal penalties, to the control of alcohol availability.

On the other hand, he said, longer-range, comprehensive programs which involve informal social controls are what's needed to reduce the problem. "The overall goal of such efforts should be to make driving after drinking too much socially unacceptable, unnecessary, and ultimately a much less frequent event in society."

Dr Simpson told the conference, sponsored by the Addiction Research Foundation here, that Canada is a society of drivers; 12 million licenced drivers in this country travel 130 billion miles annually.

Canada is also a society of drinkers. In 1979, 205 million litres of alcohol were consumed, or 12.7 drinks per week for each Canadian more than 15 years of age.

And, he added, Canada is "almost a society of drinking drivers." There are 175,000 drunk-driving convictions annually and approximately 50 million drunk-driving trips are taken each year.

But, Dr Simpson said, the problem is not a health and safety issue alone. It has economic, political, and social aspects as well.

In Canada, alcohol beverage industries employ 19,000 people and provide salaries of $450 million, in addition to $90 million in advertising and approximately $2.1 billion in revenue to Canadian governments.

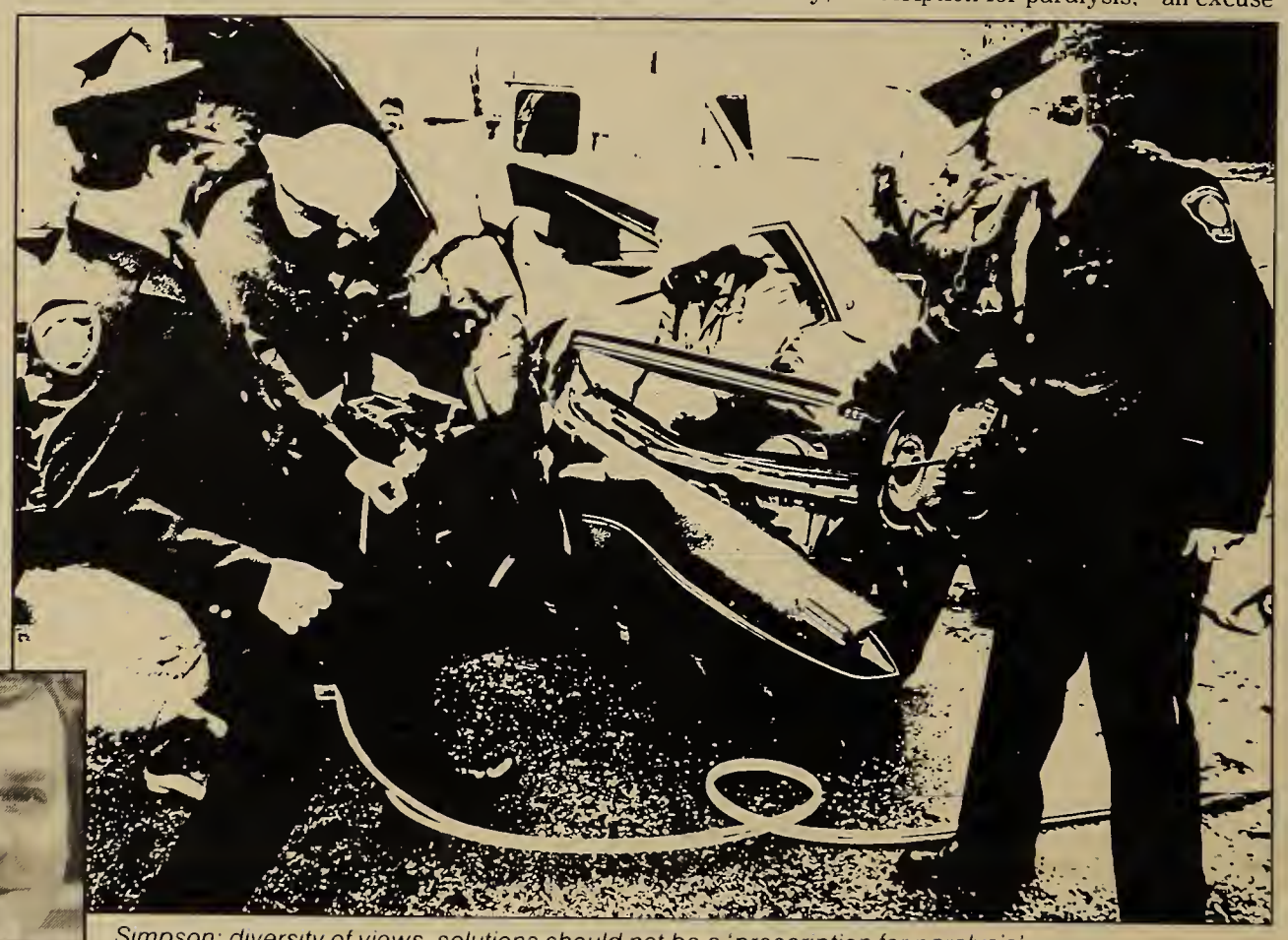
"The stakeholders are many," Dr Simpson cautioned.

And, he said, differences of opinion among people or agencies involved in responding to or dealing with the problem can add to the difficulty in finding solutions.

"Considering the number and diversity of individuals, groups, organizations, and institutions that try to study, understand, or control the problem, it would be astonishing to find a single, consensual perspective."

But this should not be a "prescription for paralysis," an excuse to do nothing, he added.

"Diversity suggests to some that efforts to produce change are futile. To others, it suggests that patience, creativity, and resolve will be the central issue for the future and progress may be slow, but it can be steady."



Simpson: diversity of views, solutions should not be a 'prescription for paralysis'

BAL for legal impairment too high: researcher

By Maureen Brosnahan

WINNIPEG — The blood-alcohol level at which a person is considered legally impaired is too high and should be lowered, says William Mulligan, MD, director of the University of Manitoba's Accident Research Unit here.

Speaking at a recent conference here on drinking and driving, Dr Mulligan said a person's ability to drive a vehicle can become impaired at levels as low as 0.03% (30 milligrams of alcohol per 100 millilitres of blood) which is much lower than the legal limit of 0.08% (80 mg).

Dr Mulligan said for a person to drive a car, the brain must control two functions: keep the car on the road and watch for signs, other traffic, and road hazards.

But, when a person drinks even a small amount of alcohol, the brain function which involves detecting a problem and processing the information is delayed, causing impairment.

He said this problem can be evident in blood-alcohol levels as low as 0.03% and 0.05%.

The current 0.08% legal limit "is probably inordinately high on average," he said.

Dr Mulligan said there is a move across the country to lower the legal limit. He said 0.08% was arbitrarily selected as the legal limit when the law was passed.

"I think we all agree it should be lower," he said. "There are some people in the community who believe it should be zero."

Dr Mulligan told the conference that studies consistently show more than half the traffic fatalities in Canada involve alcohol, and those most likely to be affected are between the ages of 18 and 24 years.

Harold Dalkie, an engineer and researcher at the unit, said between January 1981 and December 1983, there were 121 fatal automobile accidents in Winnipeg. Of those, 63 involved alcohol, and most of those caught drinking and driving were young people, even though they make up only about 22% of all drivers.

Mr Dalkie said studies show that while those between the ages of 30 and 40 years actually drink and drive more, it seems that the younger drivers are involved in more accidents.

Dr Mulligan said one problem with research and statistics on drinking and driving is that there is no comprehensive system for gathering data across Canada, and what little is available is fragmented.

Earlier, at the same conference, Alan Donelson, PhD, senior research scientist with the Traffic Injury Research Foundation in Ottawa, said researchers must begin to work more closely with community groups to solve the drinking and driving problem.

He said a lack of coordination and information means the two groups often work in isolation rather than cooperatively.

"The problem is so big and something has to be done," but asking governments to lighten or change the law is not enough, he said.

"I think we have relied too long on government to do something to us and for us. Social attitudes must change, he said.

"It will take more than words, posters, and Christmas blitzes to solve the problem."

Year-round spot checks face drivers in Winnipeg

By Maureen Brosnahan

WINNIPEG — After months of negotiations with the provincial government, city police here plan to establish a year-round spot check program to apprehend drinking drivers.

Winnipeg police traffic superintendant Mac Allen told a conference here on drinking and driving that the city will have a special van for its Alcohol Level Evaluation Roadside Testing (ALERT) program. The van, which will be operated by two police officers, contains a breath-test unit, mobile phone, and washroom.

Supt Allen said the ALERT program, begun in 1978, has been "absolutely" successful in deterring drinking drivers during the holiday season.

"We're going to have it all year round," he said. "They (the province) want the city to have a 365-day-a-year program, and that is very close to being implemented. . . . We are prepared to use it every evening of every day."

Supt Allen said deterrence and not stiffer penalties is the solution to the drinking and driving problem. He said most people don't consider the penalties involved before they drink and drive. Instead they weigh the risks of being caught.

He said the only way to control the problem is to increase the risk of being apprehended by increasing the number of spot checks and patrols.

John Bucklaschuk, provincial minister responsible for the Manitoba Public Insurance Corporation, which insures all Manitoba drivers, told the conference a year-round ALERT program will benefit all Manitobans by reducing the loss of life and productivity among people who are victims of drinking drivers.

He said the province's recently-enacted ALIVE campaign, which is directed at raising awareness of the problems of impaired drivers, is being well received. However, he added that community groups must also take action to change social attitudes and make impaired driving unacceptable.

As well, he said the province supports several measures, including legislative changes to the Criminal Code, which would crack down on impaired drivers.

In Winnipeg, Supt Allen said, increased surveillance of drinking drivers has seen the number of traffic fatalities due to alcohol drop to one in 1982 from 11 in 1978 in one target area of the city.

He said in the five years ALERT has been operating during the Christmas season, the number of people charged with impaired driving rose 300%.

SafeGrad to continue, but under fire

WINNIPEG — Despite the concerns of a Manitoba judge and officials in some communities, Safe Grad, a program designed to prevent students from driving after drinking at graduation parties, will be organized again this year in Manitoba.

The program, which originated in Saskatchewan several years ago, involves police, school and community officials, students, and parents (The Journal, April, 1984). Students attend a supervised graduation party where liquor is served, hand over their car keys on arrival, and are delivered home safely when the party ends, said Brad Sezebak, a school guidance counsellor here who helped organize some of the Safe Grad programs last year.

There were about 80 Safe Grad programs in the province last year, 10 of them in Winnipeg, he said. All were successful and no fatalities were reported.

Mr Sezebak said the key to the program's success is that they are community-based. Each town or school works to plan its own kind of party and method of supervision.

But Manitoba's Associate Chief Judge, Edwin C. Kimelman, has expressed some concern about the program, saying it encourages under-aged students at these parties to drink. This is breaking the law he said.

Ross Ramsey, executive director of the Alcoholism Foundation of Manitoba, which helped communities set up Safe Grad programs last year, admitted that there are under-aged students drinking at these parties. But he said this would happen regardless of Safe Grad, and the program is one way of "preventing kids from getting into their cars and killing themselves."

Mr Sezebak said the program does not force students to drink. He said some of the programs are organized to discourage it by charging for liquor and offering soft drinks free.

Safe Grad is a protective, supervised measure, he said. "It's just facing a problem that's real and handling it in a mature and responsible way."

FEATURES

Paper's cigarette ad ban symbolic attack on industry

By Angela Mangiacasale

KINGSTON — One Canadian newspaper's decision to stop publishing cigarette ads may not bring down the tobacco industry, but it is a significant step in the battle against smoking, say public health experts.

Tobacco advertising "is a form of negative health promotion. If you're not advertising it, you're not promoting it," says Mary Jane Ashley, MD, chairman of the preventive medicine and biostatistics department at the University of Toronto.

The Whig-Standard, a daily newspaper in Kingston, Ontario, began declining ads that promote tobacco products on January 1. In announcing the decision, publisher Michael Davies said the newspaper was putting its social conscience ahead of its commercial interests (**The Journa**l, Jan).

Jim Mintz, chief of communications and marketing for the Health Promotion Directorate of Health and Welfare Canada, called the newspaper's decision "one more nail in the old coffin" of the tobacco industry.

"If businesses like that organization start recognizing that advertising a product that kills close to 30,000 people a year in this country is not a good thing to do, that will have an effect on people," Mr Mintz told **The Journal.**

"It may not sound like a big thing that a small Canadian paper stopped taking tobacco ads, but it's the symbolic aspect that's important."

A 1982 Gallup poll of Canadian attitudes toward cigarette advertising estimated that 46% of the population more than 15 years of age would like to see these ads banned outright and another 19% would prefer to see a reduction in tobacco ads.

Those in favor of maintaining the advertising at the same level comprised 28%, while 7% said they favored an increase in those ads.

Lynn Kozlowski, PhD, senior scientist at the Addiction Research Foundation, Toronto, said the most direct effect of the ad ban may come in the media.

"If a large percentage of your income comes from tobacco advertising, you can expect less of a tendency to cover anti-tobacco stories," he told **The Journal**.

The tobacco industry has long argued that its advertising is not aimed at getting people to start smoking, but to get those who already do to switch brands.

Dr Ashley doesn't buy that argument.

"Why is the industry spending billions of dollars on advertising its products if not to recruit new smokers or at least to maintain the level of smokers they have?

"They are definitely trying to recruit new smokers, especially young people. Their ads which show young people smoking try to project an attractive lifestyle."

In a paper delivered at the 1983 Fifth World Conference on Smoking and Health in Winnipeg, Kjell Bjartveit, MD, of Norway, an adviser to the World Health Organization, explained the Norwegian experience after tobacco advertising was banned in 1975 (**The Journal**, Sept, 1983).

The ad ban came into effect under the Tobacco Act which also required health warnings on cigarette packaging. In addition, from 1980 to 1982, the price of tobacco was increased three times through tax levies.

Dr Bjartveit stressed that changes in smoking rate trends do not prove the effectiveness of the Norwegian program, but they do provide some indication of results in a country where legislation was imposed.

"Since 1957, nationwide surveys of smoking rates among students in the basic school have been conducted four times. Increasing rates were registered up to 1975, and smoking among girls in particular showed a dramatic and alarming increase, with rates in 1975 equal to or above those of boys at all age levels in the upper grades," Dr Bjartveit reported.

"In 1980, the rates were on the decline for both sexes . . . (most pronounced among) girls, who at all age levels were back again to lower smoking rates than the boys."

In Norwegian sales of cigarettes, there was an increase in per capita tobacco consumption until the 1970s, when the country's parliament endorsed a government program on smoking and health, including legislation. Since that time, Dr Bjartveit said, the per capita consumption has levelled out and, during the last few years, has shown a tendency to drop.

"If the upward trend for the 1950s and 1960s had continued into the 1970s and 1980s, we would have had today a per capita consumption which would have been about 30% higher than it is."

In Canada, the most recent survey of national smoking habits also indicates a decline in the proportion of regular smokers more than age 15.

The survey estimates that from 1970 to 1983, the percentage of adult males who regularly smoke cigarettes dropped to 34% from about 49%. During the same period, prevalence rates among women dropped to 28% from 32%.

Part of the reason for the decline may be found in the Health Promotion Directorate's campaigns against smoking.

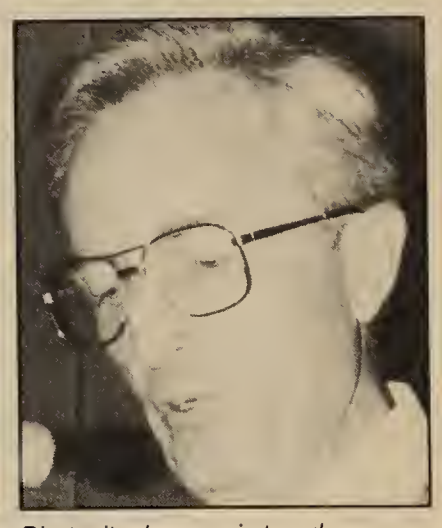
Mr Mintz has been behind the campaign to help keep young Canadians from starting to smoke. The approach is a direct counterattack on the tobacco industry's advertising campaign.

"Why are their (tobacco industry) billboards so close to schools (**The Journal**, March, 1984)? Surveys have shown that most people start smoking between the ages of 13 and 20 and if they haven't started by the time they're 20, they are less likely to ever start," Mr Mintz said.

Ashley: negative promotion

Mintz: medical costs

Kozlowski: direct media effect



Bjartveit: changes in trend

That's why the health department's campaign — under the slogan "A broken cigarette is a little freedom gained" — is aimed at adolescents aged 12 to 17 (**The Journa**l, May, 1982).

The slick advertisements of the tobacco industry, Mr Mintz said, always "show such wonderful, uplifting photos." So the non-smoking campaign of the health department has adopted the same approach.

The packaging of the message is quite sophisticated because, as Mr Mintz puts it, "you can't lay a heavy on kids. As soon as you do that, it gets their backs up and they go out and do exactly what you don't want them to do."

Instead of taking the direct line by showing black lungs or crushed cigarettes, the campaign tries to link healthy lifestyle scenes (on beaches, on hiking trails) with people who don't smoke.

"The name of the game is to make smoking unfashionable in young people's terms."

Health and Welfare Canada is spending about $1 million on its anti-smoking ads and promotions, and another $500,000 on community and school programs. According to the Newspaper Marketing Bureau Inc, of Toronto, the Canadian tobacco industry placed $19 million in advertisements solely in newspapers during 1983.

Tobacco industry spokesmen have said that as producers of a legal, widely-used, highly-taxed product, they have a right to advertise.

To that argument, Mr Mintz responds: "It's true that government collects taxes from these products, but who pays for all those people who need medical care because of smoking-related diseases? We have a universal medicare program in this country that is funded from tax dollars . . . . It seems the health care argument is often overlooked."

'We'll see double the trouble in the next five years'

Cocaine — new challenges for treatment

BOSTON — A growing population of cocaine addicts is confusing health care professionals who are trying to work out appropriate treatment plans.

In a seminar here for the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA), Arville Stephen described the cocaine abuser as one who "does not fit the usual pattern of addiction."

Depicting cocaine addiction as a "whole new ball game," Ms Stephen, clinical director of out-patient services for the Human Resource Institute here, said: "We don't know how cocaine is affecting the system, and we have to be open to various treatment approaches without letting our ideologies get in the way.

"This is the drug of our age," said Ms Stephen. "I have never seen a drug that fits so nicely with our non-stop, go-getter lifestyle."

She sees a need for balance between mental health and self-help approaches to cocaine addiction, and estimates "we are only at the halfway point with cocaine, and will see double the trouble in the next five years."

The cocaine addict's history, unlike the heroin addict's, shows less likelihood that family patterns of alcoholism exist, she said.

Describing deviant traits of heroin users in their early years, she said the cocaine abuser, "if anything, has been too good, has done everything right . . . but just does not *feel* right."

A major problem of treating cocaine abusers is that "they just don't feel deviant." It is difficult for them to relate to Narcotics Anonymous or AA (Alcoholics Anonymous), "although they desperately need support.

Stephen: the drug of our age

"Cocaine abusers get into difficulty by accident," said Ms Stephen. "They see cocaine as a benign drug. They're the best-looking people I can think of. They present themselves as extremely attractive. They're well groomed and articulate. They're very concerned about how things look on the outside, and they're quite out of touch with who they are inside."

Many cocaine abusers easily fit the diagnosis of narcissistic personality. "Cocaine serves as their glue. Using it they say, 'I look good and I feel good.' "

At first the drug elevates the user's mood, she explained. Self-confidence increases.

As tolerance builds, and more of the drug is needed to reach a euphoric state, "they get stuck with the feelings they are trying to avoid."

The sense of competence turns to discouraged thinking and disrupted attention. Addicts become irritable, impulsive, unable to sit still, and hyper-vigilant.

"When exhaustion sets in, and money for the drug runs out, the abuser is at high risk for depression and suicide," said Ms Stephen.

Alcohol is used by cocaine addicts to mellow out the "ragged edges" of their highs. "They use alcohol as an attempt at self-medication. But as the cocaine leaves their system, and the alcohol lingers, they become extremely vulnerable to accidents."

Cocaine is "extremely seductive" said Ms Stephen. "Even with daily appointments, we've had no luck with intravenous and freebase users unless we've sent them to long-term treatment. They need a safe place to withdraw to."

Less-severely-impaired clients can often be helped by counselling and certain psychopharmaceuticals.

She said from "recreational use" to "trouble with the drug" takes about five years. Two-thirds of users are white males. Age 30 is the mean, with 14.5 years of education. Heaviest use is in the northeast United States, Florida, and California.

Seeing cocaine as a "mainstream drug," Ms Stephen now believes "we should look at the cocaine user in much the same way we look at the alcohol abuser." She is urging clients to attend AA meetings.

"We're wondering how to get cocaine addicts into treatment before a major crisis, and we're still trying to figure out the right approach to treatment," she said.

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053 Advertising 595-6113 Subscriptions 595-6056

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Why oppose ingredient labels?

Industry short on commitment

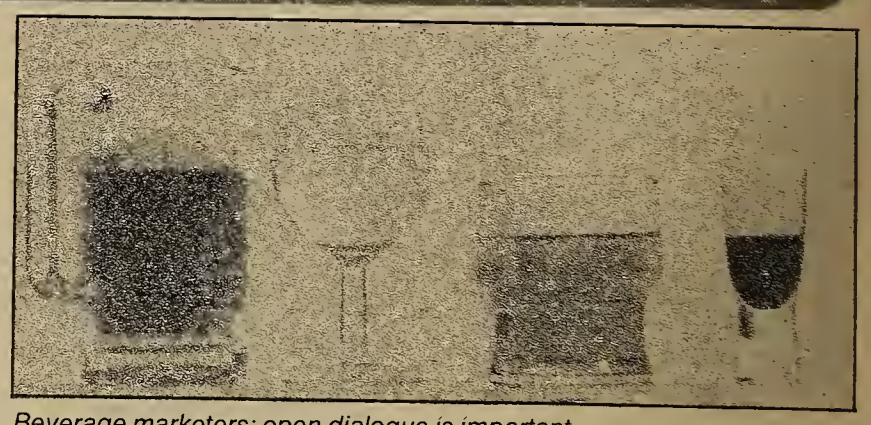
I am writing in response to Harvey McConnell's report — US beverage industry answers its critics (**The Journal**, Nov, 1984) — on a session at the annual conference of the Alcohol and Drug Problems Association of North America (ADPA). The session featured presentations by representatives of the distillers, vintners, and brewers of the United States.

While Mr McConnell did a commendable job of reporting on the presentations of the alcohol beverage industry, he failed to complete the story by reporting on the dialogue which occurred subsequent to the presentations.

While it is true that the beverage industry has displayed greater responsibility, both in terms of its marketing practices and its educational campaigns, the industry seems genuinely baffled that they are still held suspect. During the session at the ADPA conference, the industry's representatives said a great deal that was positive, and exhibited what I perceive to be a genuine desire to communicate the industry's sense of responsibility. However, contrary to the messages of responsibility and concern for people's health and well-being, the industry, for the most part, has remained opposed to something as innocuous as ingredient labelling.

* * *

Since the industry is cognizant of the fact that the public is becoming more health conscious and, as a result, is more aware of what it consumes, and since the industry claims to want to be an integral part of promoting a healthy and responsible society, why is there any opposition, whatsoever, to something as simple as ingredient labelling. The industry, in my estimation, will never appear to be credible as long as it continues to oppose such issues.



Beverage marketers: open dialogue is important

While I believe open dialogue with the industry is important, I think there will never be a complete coming together of those who promote the sale of alcoholic beverages and those who advocate for the prevention of problems attributable to alcohol. While there is room for middle ground, the goals of profit and prevention are typically in conflict. The industry's position on ingredient labelling seriously narrows the middle ground.

Wayne Lindstrom, Chief
Bureau on Alcohol Abuse and Alcoholism Recovery
Department of Health
State of Ohio
Columbus, Ohio

Reader applauds paper's cigarette advertising ban

Now that *The Kingston Whig-Standard* has set a national standard of excellence in banning cigarette advertising from its pages (**The Journal**, Jan), strongly supported by our new federal Health Minister, Jake Epp, can other Canadian newspapers fail to follow?

Publisher Michael Davies, recognizing that tobacco advertising and promotion no longer deserves media approval, is to be commended for taking this bold, courageous step. As a non-medical practitioner of preventive medicine, he clearly demonstrates to his peers the value and impact of one man's determination to take a public stand on the tobacco issue.

His is, in my opinion, a superb example of how to act locally while thinking globally on a matter which concerns us all.

George F. Lewis
Associate professor, Anatomy
McMaster University
Hamilton, Ont

New subscriber still interested

At one time in British Columbia when I worked at Canada Post, I was very much involved with addiction research (booze).

I am now retired and am still very interested in what is going on in this and other fields.

It is through my doctor now that I am concerned.

Please add my name to your subscription list.

D.H.
Ottawa, Ont

Correction

In the January issue of **The Journal**, Dr Luther Terry, former United States surgeon-general was incorrectly identified as Dr Terry Luther (Kingston newspaper first in Canada to prohibit tobacco advertisements).

The Journal regrets the error.

Families feature excellent comprehensive

The format and coverage relative to children of alcoholics (Families and Alcohol: a legacy of love and pain — **The Journal**, Oct, 1984) was excellent.

The articles offer a succinct highlighting of the major points in each paper presented. Collectively, they have addressed every conceivable issue, affective responses, and hypotheses of current or projected outcomes for such individuals or families.

I would add that while there is considerable concern about the adult children of alcoholics, we should not lose sight of the current, young children of alcoholics and their needs.

Kathleen Michael
Youth and Family Consultant
Addiction Research Foundation
Toronto, Ont

The Journal welcomes letters to the editor. Letters bearing the full name and address of the sender may be sent to: The Journal, 33 Russell St, Toronto, Canada M5S 2S1

BACKGROUNDER

Global accord sought to take profit out of trafficking

Current international controls are inadequate to support effective actions to trace, seize, freeze, and forfeit the profits of drug-trafficking crimes, says Superintendent Rodney T. Stamler, Officer-in-Charge, Drug Enforcement Branch, Royal Canadian Mounted Police.

Supt Stamler and other international experts, at the invitation of the United Nations Division of Narcotic Drugs, have addressed the complex issues of drug-related money flow. Their recommendations will be presented later this month to the 31st session of the UN Commission on Narcotic Drugs. They include, says Supt Stamler, mechanisms which would facilitate, at both national and international levels, effective, concerted action to deprive traffickers of profits.

It is expected that the recommendations, which were under a publication embargo at The Journal's press time and until the meeting, will include a proposal for an instrument to supplement provisions of the existing international drug control treaties.

Supt Stamler's views on the forfeiture of the profits and proceeds of drug crime are presented by The Journal below, adapted by Contributing Editor Karin Maltby from various documents Supt Stamler has prepared, including the National Drug Intelligence Estimate (The Journal, Jan).

Next month The Journal will report on the reactions of member states of the Commission to the recommendations.

Drug trafficking is dominated by organized, criminal syndicates whose sole purpose is to secure profit and power. Generated by street drug sales, an unlimited flow of money moves upwards to high-level, international criminals. These profits perpetuate drug distribution networks which function without regard for national boundaries.

Bribes, pay-offs, and the corruption of public officials are only a few of the acts that trafficking organizations carry out. Their vast profits are laundered and reinvested into legal and quasi-legal business ventures providing a shield of respectability to their leaders.

The risks involved are low for these criminals who may never come into direct contact with drugs. Syndicates flourish as trafficking generates more revenue for them than any other criminal activity.

For example, an illicit opium producer may receive $500 to $800 (Cdn) for 10 kilograms of opium, which in turn produces 1 kg of pure heroin that sells, in production areas, for about $5,000. When it, in turn, is delivered to distribution centres, it may sell for $75,000 at the *wholesale* level. Diluted to street-level purity (and divided into small amounts), it can generate up to $12 million.

Bank secrecy and tax havens

Illegally acquired profits are converted into legitimate operations by complex schemes of money laundering. Once these profits have been "cleaned," they may be injected into the regular economy by way of acquisition or infiltration of legitimate business. And, although a trafficker may be imprisoned for a lengthy period, his laundered and reinvested profits will be waiting for him upon release.

Many national laws and international systems are inadequate to cope with the tracing, freezing, or seizure of these profits because there is a preoccupation with isolated offences which imprison individuals but leave criminal organizations intact. And while the ownership of money can often be established, if it remains within the national boundaries of a state, once transferred outside those boundaries, it becomes cloaked in perpetual anonymity.

Jurisdictions with protected secret banking and corporate privileges have grown in popularity and attract both individuals and criminal organizations. The development of banking systems and international business and commerce have made it easy to create laundering systems designed to move money directly into foreign banks protected from intrusion by law enforcement officials.

For the trafficker, this financial privacy is an indispensable aid in concealing the profits derived from the sale of illicit drugs.

Money-laundering schemes

In one case, for example, a trafficking syndicate used one part of its organization to manage drug distribution and a separate part to collect the money. The individuals who collected the money never made contact with those who distributed the drugs. Profits were eventually received by a major travel agency and then distributed to higher-level syndicate leaders and to the individuals involved in the drug distribution and money-collecting parts of the organization. The travel agency had allied offices in South America, which arranged for payouts to be made to those involved in the operation in the South American countries involved. Actual movement of the funds didn't take place until drug distribution had been finalized, making it difficult to connect the monetary transactions to specific drug transactions.

In another case, a trafficker testified that to facilitate the laundering of his profits from his cannabis operation, he incorporated a company in one tax-haven jurisdiction, which in turn held the profits of his drug operation in a bank in another tax-haven country. Both countries have strong bank- and corporate-secrecy laws.

The involvement of traffickers in such crimes undermines the international banking system and other institutions concerned with legitimate trade and commerce, and may threaten the integrity of some governments.

International law enforcement

More countries make it a crime to release banking information than consider the possession of the proceeds of drug trafficking a criminal offence.

Two existing international drug-control conventions (the Single Convention on Narcotic Drugs and the Convention on Psychotropic Substances) have facilitated both the arrest of many couriers and low-level traffickers who move from one country to another, and the seizure of illicit drugs. But there is no international agreement on tracking the flow of such proceeds, their eventual seizure, and the prosecution of high-level criminals.

If possession of drug-crime proceeds is not an offence, then little investigative action can be taken to trace the money flow from illicit drug sales. As a result, only the property of those people who have been convicted of trafficking in the same state where the property is situated will likely be subject to confiscation. This approach will do little to identify and prosecute the organized criminals who control the international syndicates.

The act of acquiring, possessing, or using the profits derived from international trafficking should be made a criminal offence. If an international instrument with provisions against such crime were in effect, it would aid the establishment of national laws and procedures to trace, seize, freeze, and forfeit proceeds of drug offences.

United Nations action

The UN Commission on Narcotic Drugs, at its February 1983 session, recognized that depriving traffickers of their profits would be an effective way of reducing illicit trafficking. It later provided guidelines for action against international drug trafficking and related criminal activities.

The first expert meeting on forfeiture of drug-related assets was convened by the UN Division of Narcotic Drugs in October 1983.

The meeting concluded that the lack of criminal laws in many jurisdictions prohibiting the possession of illegal assets, makes it impossible to investigate such assets and provide judicial cooperation between states.

The expert group noted that the existing drug control treaties provide a framework for the development of both national legislation and bilateral agreements, and recommended that:

- National legislation should declare it an offence knowingly to have the possession or disposition of drug-trafficking assets, whether such trafficking took place within the same state or in a foreign jurisdiction.
- Consideration should be given to supplementing and augmenting the existing drug treaties, or to adopting a separate convention which would guide member states when considering amending legislation to aid the tracing and forfeiture of drug-crime profits.
- The Commission on Narcotic Drugs should consider proposing a convention or protocol in order to cover the gathering of evidence to ensure the forfeiture of the profits and proceeds of drug crimes. The Commission might also consider convening an expert group to draft an instrument along these lines.

A second meeting of the expert group was held in late 1984. The meeting concluded that the most appropriate approach would be to negotiate an international instrument which would include clauses addressing the problematic issues and which would be open to adherence by member states.

The group also concluded that the knowing acquisition, possession, use, or laundering of the proceeds of drug trafficking should be a crime, irrespective of where the trafficking occurred. It was recommended that such crimes should be included in the penal provisions of the proposed international agreement, to allow for effective action to trace, freeze, seize, and forfeit drug profits which would be found in domestic territory, and to prosecute those people who knowingly possessed, used, or acquired such proceeds.

Conclusions

The expert group recommended the basic elements which are necessary to take effective national and international actions against traffickers to remove the profits for their illicit activities.

If adopted, the measures would permit each member state to take action against the proceeds of drug crimes within its domestic territory and to prosecute those involved.

Knowledge that the proceeds have been derived from drug trafficking is an essential element of the offence. This concept will protect legitimate third parties who come into contact, possession, or control of the proceeds innocently and *bona fide*. While it will protect the banks, their employees, and other people who possess or control funds without knowledge of the drug crime, it will permit law enforcement authorities to trace and investigate the possession of that property which is connected with, or derived from, drug crimes.

The proposed measures follow closely the pattern established by the existing drug control treaties. The current enforcement of provisions against drug offences at the international level is effective because every state treats the trafficking of illicit drugs as a crime.

It may be desirable that the same approach be adopted for the proceeds of drug trafficking. The adoption of an international instrument to expand the existing drug control conventions is an important step to ensure international cooperation.

The adoption of "model" provisions contained in the recommendations of the expert group would resolve one of the main problems facing states in their attempt to dismantle drug trafficking syndicates that control the international, illicit drug trade.

Supt Stamler

INTERNATIONAL

'Criminalization prevents those in need from seeking help'

Sweden planning sweeping anti-drug action

By Thomas Land

STOCKHOLM — Sweden is about to intensify its fight against drug addiction, especially among unemployed and maladjusted young people.

Proposals placed before parliament here by the government seek the release of 100 million Krona (Cdn $14.4 million) for a series of preventive measures, including community-based anti-drug campaigns at sport and recreation centres, backed by the media.

The administration also wants to strengthen the social services, the police forces, and the office of the public prosecutor. It has asked for funds to invest in computer equipment for the customs office and for authority to grant customs investigators access to relevant police records.

In addition, the government proposes to double Sweden's Kr 8 million contribution to the United Nations Fund for Drug Abuse Control and seeks further financial aid to support crop substitution projects in opium-poppy growing regions.

Both possession and trafficking of narcotics are punishable by up to 10 years imprisonment — indeed, they are among the most serious crimes under Swedish law. The government proposes some changes in the penalty system, while recommending the continued decriminalization of drug abuse itself. Its policy is based on the belief that criminalization of drug use would prevent those in need from seeking help.

Sweden embarked on its present policy in 1968 when parliament adopted a set of tough, commonsense guidelines. A report just published by the ministry of social affairs here appears to justify its wisdom in statistical terms.

Facing a deteriorating situation, with a growing population of perhaps 14,000 "heavily" addicted heroin abusers, parliament has introduced sweeping social and criminal law reforms. The penal code was tightened to its present level by stages; the police and customs services were given increased resources and broadened powers (including special authority for wire-tapping under carefully defined circumstances); and the nation's health information and education activities were reinforced.

Today, the social affairs ministry says in its new study drug abuse is no longer on the increase.

Stockholm: major shifts in population have created fertile ground for drug abuse among youth

In this country, at least, experimentation with drugs by young people is on the decline, with heroin increasingly being replaced by drugs such as marijuana and amphetamines.

The legislative proposals now placed before parliament are thus intended to intensify the trend. Their emphasis on the plight of unemployed and maladjusted youth is based on the underlying philosophy of the national drug control policy.

It identifies the inability of many young people to come to terms with the pressures of modern life as the essential cause propelling them toward drug abuse.

Many recent Swedish studies portray drug abusers as a group that differs from the general population by originating from relatively disadvantaged backgrounds and insecure home environments. They often make their "abuse debut" when reaching puberty.

The problem is widened in the adult world by the dominant motives of profitability and efficiency in the workplace, advancing technology's control of human performance and production patterns, and the failure of many people to find meaningful employment. The process of structural change that has led to major shifts of population has created fertile ground for drug abuse, as well as other social ills, by encouraging isolation, loneliness, alienation, competition, and indifference.

All of which may just describe a difficult but passing phase while society learns to adjust to the conditions imposed by advancing technology. In the meantime, Swedes seek to support their young people, who are least equipped to cope with the change, and to protect them from exploitation by drug traffickers.

Heroin use by very young Italy's chief concern

ROME — Drug addiction is a growing problem in Italy and is attracting considerable attention as a public issue. But the problems of alcohol abuse and alcoholism have not been addressed through any organized public policy.

Heroin deaths have increased nearly 20% during the past year, says Sara Cuneo, alcohol and drug abuse consultant for Italy's minister of the interior.

"The spread of heroin use among the very young is one of our most important problems," says Ms Cuneo. "Heroin deaths are occurring in the early 20s age group, and 13 and 14 year olds are using heroin."

Ms Cuneo told **The Journal** that alcohol and heroin are being used in combination. "Amphetamines were popular for a long time, but now sedatives are the drug of choice."

Drug-related crime has been increasing dramatically during the past five years, "especially when it comes to robberies."

Ms Cuneo paints a picture that includes battles between gangs involved in drug traffic, a well-organized drug market, thousands of miles of coastline which make it difficult to control smuggling, heavy tourist travel in Italy, smuggling on trucks and trains entering northern Italy, drug control centres being set up in police departments, and complex drug laws now being rewritten.

The emphasis in national laws, she says, is on prevention, with a goal of rehabilitation for drug addicts, as opposed to treating them as criminals. "The laws are good," she says, "but difficult to enforce."

Most heroin used in Italy originates in Thailand "and is refined either there or here," says Ms Cuneo, noting that drug traffic is coming through Russia and China.

The current law permits possession "of a small quantity for personal use," explains Ms Cuneo. "Interpretation of what is a 'small quantity' poses problems when it comes to enforcement. Decentralization of treatment has been provided for in the laws, but it is hard to see clearly what is supposed to happen at local and regional levels."

The Italian government sponsors drug intervention centres similar to hospitals, and hospitals provide whole sections for drug addicts.

Rome: tourists a link in trafficking cycle

Ms Cuneo, describing a 1984 study of drug-related deaths in which autopsies had been performed, noted the high prevalence of heroin misuse in combination with other substances.

Of 116 deaths, 71 involved heroin with alcohol; 21 showed heroin in combination with psychopharmaceuticals; seven showed a mixture of heroin and cocaine; and five involved heroin, cocaine, and psychopharmaceuticals.

Two cases found methadone used in combination with cocaine or another substance. In one case, heroin was found in combination with marijuana. There was one four-way blend of heroin, cocaine, barbiturates, and alcohol. The remaining cases were three-way combinations such as heroin together with methadone and psychopharmaceuticals.

"Prevention" is the most important word in Ms Cuneo's drug-related vocabulary, especially concerning the young.

At *Il Centro Italiano di Solidarieta*, near Rome's River Tiber, Juan Corelli directs a comprehensive therapeutic program for drug addicts and their families.

He corroborates Ms Cuneo's view that heroin use is the leading drug problem in Italy. "We're traditionally a smuggling country," he says. "Control of drug traffic is difficult. And the heroin situation is getting worse."

He says "drug traffic is a huge money business," and believes the answer lies in primary prevention efforts.

"Drug abuse is not a problem of drugs," he told **The Journal**. "It's always a problem of man, and to help man you need many modalities."

His voluntary institution focuses on *Project Man*, which "considers men with all their faults, needs, and aspirations." The centre's network includes residential treatment, a re-entry facility, day care, a research centre, a training school for workers, and a family association.

The priority goal in treatment of drug addicts, says Mr Corelli, ". . . is to give them tools to help them get back at the wheel and regain control over their lives."

He is convinced people turn to drugs to avoid solving their personal problems. "They need a sense of values and the freedom to take their lives in their own hands and make life decisions."

Cuneo: ambiguous on alcohol

All addictions have "the same stamp," he adds. "The addict has the necessity to use *things* to feel better. But the real need is to be happy with oneself."

He would like to see more early education designed to help young people "avoid chemical dependence from the beginning." The centre, making it a point to work closely with schools, provides drug experts who train teachers in prevention education.

Mr Corelli sees alcohol abuse as a major problem, but one that dates back "more than 2,000 years," making it a "less dramatic issue than drug addiction."

Using similar words, Ms Cuneo says: "Alcohol, which is now showing up heavily in combination with heroin, has always been a problem but has never been a scandal. Drunkenness has been accepted."

There are villages in Italy, she says, in which all the men get drunk on weekends. In the many parks that abound here in Rome, sleeping drunks are part of the accepted atmosphere.

The government, says Ms Cuneo, is in an "ambiguous" position on the issue of alcohol abuse. Alcohol is used legally at all ages and the state has a monopoly on the buying and selling of alcohol.

"Italians are used to seeing drunks in the street, but they're not used to seeing drug addicts," she adds.

There are local clubs for alcoholics, similar to Alcoholics Anonymous, but the government has no comprehensive approach for dealing with alcohol issues.

Corelli: a smuggling country

European nations eye ways to tap drug money flow

By Thomas Land

PARIS — Legislation to provide for the judicial seizure of the financial assets of drug traffickers may be introduced shortly in several European countries.

Coordinated legislative action is being sought by the governments of 14 Council of Europe countries backed by the United Nations. A judicial committee of inquiry in Britain recently declared its support for such reform after four years of deliberation.

Europe's law makers may thus follow the example of Australia which passed legislation in 1979 obliging people convicted of serious drug offences to prove the legal origin of their assets.

As one European chief of police put it at a recent conference: "I think it would have a deterrent effect if drug dealers went to court knowing that they could lose their cars, houses, and finances — as they do in Australia as well as the United States."

A communiqué issued after a ministerial meeting here of the "Pompidou Group" of countries identifies the tracing and confiscation of the financial assets of drug traffickers as its governments' top priority in their common fight against addiction. A conference of experts brought together by the group had earlier recommended legislative reform to empower the courts to take such action.

Other priority areas listed by the group include the improvement of methods used in the treatment of addiction, particularly in the case of the "high-risk" young, as well as measures to combat drug trafficking on the high seas.

The group was formed in 1971 at the suggestion of the late President Georges Pompidou of France to seek a common approach to drug addiction. Its members are Belgium, Britain, Denmark, France, Greece, Ireland, Italy, Luxembourg, The Netherlands, Norway, Spain, Sweden, Turkey, and West Germany.

Their accord represents an important new departure. Many of them have hitherto ignored the persistent call made for some years by the UN Commission on Narcotic Drugs to governments and international organizations to create the conditions for the forfeiture of the drug profits of convicted traffickers. The commission is concerned that money and other assets gained by trafficking are often used to finance further black-market activities.

One of the first countries of the group to act may be Britain where

Pompidou: alliance in his name

Home Secretary Leon Brittan has promised legislation to fight "the alarming upsurge in the abuse of dangerous drugs" by "depriving drug-smugglers of the proceeds of their crimes."

Mr Brittan recently received a closely argued 160-page report, compiled by an independent committee of inquiry under a high court judge, recommending such reform. The committee was set up amidst public outcry greeting a ruling by the House of Lords — the highest legal authority of the country — that the courts lacked the power to confiscate the profits of a drug ring smashed in Operation Julie (**The Journal**, Feb, 1984, July, 1980).

The committee sought urgent change in the law enabling criminal courts to make confiscation orders depriving criminals of the profit of their crimes and to freeze assets before trial. Third parties — such as the wives of criminals — could also be affected. The street value of drugs would be considered as an indication of the size of illegally acquired assets.

Europe's population of drug addicts is variously estimated in terms of several hundreds of thousands. Addiction is spreading at an accelerating rate, particularly among the growing numbers of the young unemployed who face extreme pressures and bleak prospects in a shrinking job market.

See — Drug Money — page 9

Sobriety may precipitate new family problems

By Michael Kesse

JERUSALEM — Family difficulties requiring professional help often result when a husband completes alcoholism treatment and becomes abstinent.

This conclusion was reached after questioning 58 Israeli wives, most of whom reiterated a similar statement: "Everyone thinks that since my husband stopped drinking, all our problems were solved."

Variations of this basic idea, that paradise did not follow sobriety, were: "I never imagined it would be so difficult after he stopped drinking," or "when my husband doesn't drink he behaves differently, in ways I've forgotten about, or never knew he had."

The project was conducted by Ruben Bauml of the Alcoholism Treatment and Prevention Program, ministry of labor and social affairs here, and Pnina Eldar, program director.

It reinforced and confirmed the results of other investigators (**The Journal**, Oct, 1984) that "the alcoholic family learned in stages, by a process of trial and error, how to cope with and adjust to, the alcoholic member's behavior."

But this homeostasis is smashed when sobriety — "a sudden change" — takes place. The family balance is badly disturbed as the recovered alcoholic finds himself seeking a meaningful role within the family. This creates conflict with other family members who see his new role as a "threat," Mr Bauml told the International Congress on Alcohol Dependence, the Family and the Community here.

The alcoholic family, which gradually develops the characteristics of a pathological family, living, as it has, under stress for years, suddenly finds itself in a situation where the former drunkenness was easier to cope with than the present sobriety.

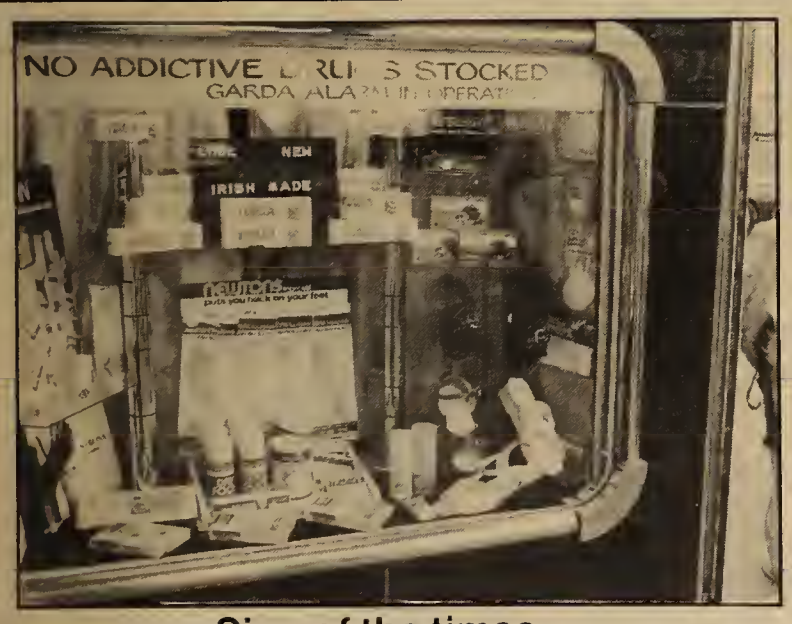
Mr Bauml described seven stages of "adjustment."

- Most families consider the father's current abstinence as an insignificant event since other periods of sobriety have occurred in the past.
- When sobriety continues, the family tempers its non-belief with hope.
- The family begins to accept the new status and enters a state of euphoria. There is an actual "family honeymoon," and many unrealistic expectations about the future emerge. The family ignores objective family difficulties since they seem so easy to solve.
- The family is hastily reorganized, and the former alcoholic reveals himself as he really is, with all his problems, abilities, and shortcomings. He discovers that his problems, when sober, are often greater than his alcoholic ones.
- Stress builds up. The family has no tools to deal with these new problems, and tends to see fewer and fewer advantages in the father's abstinent state, and more advantages in the alcoholic one, which they had the tools to handle.
- The family enters a phase of disorganization and confusion. Two sets of clashing behavior patterns are involved; one inherited from the drinking period, the other beginning to take form from the sobriety period.
- The sobriety behavior pattern takes over, and a new homeostasis is achieved.

Mr Bauml notes that although "each family differs, and the stages in the process can vary accordingly, several valid conclusions emerge."

The end of the drinking should not be regarded as the final goal of treatment, but rather as the beginning of a new and critical period of treatment. The family must be thoroughly prepared to face the possibility of having new problems and difficulties, and the family should be helped to cope when expectations for sobriety fail to materialize.

Finally, the family should be persuaded to moderate its initial extreme reaction and to avoid making any significant family decisions during the first few months of the sobriety process.



Sign of the times

A chemist's window warning in Dublin, Ireland, takes the direct apporach — telling drug thieves not to bother

UK clinic tries 'drink sensibly' advice for clients

By Alan Massam

LONDON — A special advisory service to help people who drink "a little too much" avoid becoming dependent on alcohol, has been introduced here.

Based on techniques pioncered in Canada, it will seek to reduce drinking without recommending abstinence.

The service is being operated by George Lanagan, former director of the National Council on Alcoholism, from the Bowden House Clinic, Harrow-on-the-Hill, Middlesex.

Mr Lanagan: "Modern research shows that for most people a drink or two is not harmful, but for those who over-drink often, work performance suffers. Many are skilled people, key personnel in whom their companies have invested large training sums. The loss is both to the employer and the employee.

"It is a waste in both human and economic terms which needs to be stemmed."

The Bowden House Clinic is managed by St Andrew's Hospital, Northampton, which is Britain's largest independent psychiatric hospital. Its "sensible drinking" program requires only one or two hours attendance each week and includes counselling and guidance on how to reduce drinking.

Cargo X-ray system detects alcohol, drugs

By Thomas Land

LONDON — A group of companies here has received an export order for two automatic cargo examination systems designed to detect contraband such as alcohol, other drugs, and weapons — without the cargo's having to be unloaded or damaged.

This is believed to be the first order for such systems. The identity of the client has been withheld for security reasons. It may be a country, like Canada or the United States, disturbed by the disastrous current rise in the volume of illegal narcotics dispatched across international frontiers by the global crime syndicates.

The system uses X-ray and spectographic gas analysis on the cargo as it moves forward on the conveyors.

A specialist spokesman for British Aerospace, the company leading the designers of the system, explains: "Typically, 20 containers an hour may be examined; and this high throughput would be of immense value to port and customs authorities who at present must open every container for inspection — a process which may take one or two hours to complete — or wave it through unexamined." The other companies associated with the venture are Taylor Woodrow, Rolls Royce, Radiation Dynamics, and Sciex.

The two systems specified in the first order are to cost more than £40 million (Cdn $65.2 million) and should be ready in early 1986. The British companies expect keen international interest in the automatic cargo examination system which they regard as an effective, potential first line of defence against the drug syndicates.

During two months of 1984 alone, British customs authorities seized £10 million (Cdn $16.3 million) worth of high-quality heroin from Pakistan — half the amount of the total customs haul in 1983.

An estimated 90% of the heroin smuggled into Britain originates in Pakistan — but customs authorities throughout the Western world fear a "flood" of illicit exports from Burma, Laos, and Thailand following bumper opium poppy crops in the Golden Triangle area.

Despite the rise in the level of drug addiction throughout the rich West, heroin supplies are outpacing demand — thereby promoting further addiction. Hence, the global interest in every means of improving customs efficiency.

British Aerospace says containers and even complete vehicles at air and seaports will be first subjected to a gas spectrographic "sniffer" system to determine whether molecules of prohibited substances, such as alcohol, other drugs, and explosives, are present in the air adjacent to the cargo. If so, they will be sent for manual examination. Containers passing the sniffer test will be moved on an automatic conveyer into a building designed for X-ray analysis.

The cargo is to be visually examined next by X-rays passed through the containers and focused onto special screens viewed by closed-circuit television. The X-ray pictures will have a zoom facility for the examination of details. The complete operation will be controlled by computer with a memory for pictures. There is no risk of damaging the cargo (except livestock and unprocessed film) and no fears of residual radiation.

The designers expect the system to speed the safe movement of goods through the ports while cutting costs and claims associated with the current methods of cargo examination. And they hope it will help to reduce the illegal traffic partly through improved detection and partly by its likely deterrent effect.

NEWS

New surgical technique can close holes

Cocaine boosting stats on nasal septum damage

LAS VEGAS — Cocaine abuse is becoming the most common cause of, and the cause of the most serious, holes in the nasal septum, says a physician who has developed a surgical technique effective in closing holes caused by use of the drug.

Marc Karlan, MD, associate professor of otolaryngology, Northwestern Medical School, Chicago, told **The Journal** earlier studies showed that 75% of such perforations were caused by surgery. Now, 40% to 50% can be traced specifically to cocaine abuse.

Dr Karlan was a speaker at the annual meeting here of the American Academy of Otolaryngology — Head and Neck Surgery.

"The mucous membranes of the septum, because of the airflow when inhaling toxic particles, are specifically damaged by cocaine," Dr Karlan said.

When inhaled, cocaine particles flow up and back along the septum "and the whole area, in somebody who's really using cocaine, is damaged."

This can lead to holes of more than three centimetres in the interior of the nose, larger than those created by other means, he explained.

Traditionally, he said, the mucous membranes of the septum are used to close the hole in the septum. But, with damage caused by cocaine use, this technique is "not as successful because the membranes that ordinarily would be used to close the perforation are damaged."

With cocaine abuse, he said, the use of this method is not effective, even if there isn't an actual hole in the septum but just a degree of wear.

Dr Karlan explained why his surgical technique, which still uses a flap to close the hole, is so successful.

"The flap that we use, from the floor of the nose and underneath the inferior turbinate, is out of the path of the cocaine particles when inhaled, and, because of that, its vascular supply and the tissue is relatively uncompromised compared with the tissue of the septum itself.

"So, we are able to close large perforations with predictable success."

Dr Karlan told **The Journal** he has used this technique with about 20 cases. This is not a large number, but he pointed out that no surgeon does many operations to close nasal septum perforations.

In his own practice, Dr Karlan said he is beginning to see more such injuries caused by cocaine abuse, and he said he gets many referrals from other physicians of patients who are still using the drug.

"I won't operate on them if they are in the middle of the habit," he said.

Another member of the panel on which Dr Karlan participated went even further.

Eugene Tardy, a Chicago surgeon and president-elect of the academy, said he generally refuses to operate on patients — including cocaine abusers — with self-inflicted septal perforations.

MDs still missing addictions

FREDERICTON — Although 30% to 40% of hospital patients have an alcohol- or other drug-related problem in addition to their primary illness, only 2.5% are diagnosed and, of these, less than 10% are referred for rehabilitative treatment.

G. Everett Chalmers, MD, chairman of the Alcohol and Drug Dependency Commission of New Brunswick (ADDC), warned health care workers here that one of the most difficult problems facing them is the recognition of early signs of alcoholism or other drug abuse.

"It is easily seen that people with additional disabilities, of whatever nature, are often overlooked or ignored. The scope of information on the multi-disabled with alcohol and/or drug problems is limited. Hard data and statistics are minimal," he said.

In response to an increased public awareness of both the special needs of the disabled and their legal right to full access to information, treatment, and other services, the ADDC some time ago established a program paying special attention to groups such as the disabled, youth, women, the elderly, and Native people.

Dr Chalmers said that based on one United States source, alcohol problems among the multi-disabled are estimated to be at least as great as the general population rate of 8% to 10%, and could be as high as 25%. Researchers established that in one group of 47 people with traumatic spinal cord injuries, 62% were alcohol or other drug dependent.

They found a tendency for patients to resume alcohol or other drug use as they became more physically active and as social interaction increased. "Alcohol and drugs may become more debilitating to their rehabilitation than their physical, mental, or other disability," Dr Chalmers cautioned.

Negative public perceptions, poor self-images, and other mental and physical barriers prompt some patients, "and more so the multi-disabled," to conceal drinking or drug use histories from doctors and health professionals.

Dr Chalmers urged doctors to become more involved with the intervention process by working closely with other health care professionals. The combination, he said, might promote patient confidence and encourage acceptance of treatment.

The ADDC chairman urged the New Brunswick Medical Society to begin a campaign of identification, treatment, or referral for treatment for the 40% of their patients who have an alcohol or other drug problem, with particular attention to the multi-disabled.

Alcohol, tobacco, other drugs chief offenders

Lifestyle ills overloading health care system

By Betty Lou Lee

MONTREAL — One-third of the intensive care costs at a major Canadian hospital can be attributed to disease and injury related to lifestyle.

Alcohol, tobacco, and drug overdoses are major factors.

Lawrence P. Schnurr, MD, director, intensive care, Foothills Hospital, Calgary, analyzed admissions to the nine-bed unit over five months and found that 36% of the cases could be related to lifestyle. The unit has a budget of $2 million a year, he said.

The 828-bed teaching hospital is a referral centre for a population of 1.2 million in southern Alberta.

Included in the lifestyle conditions were motor vehicle accidents involving drinking and driving, or failure to wear seat belts; alcoholic cirrhosis leading to hemorrhage and/or encephalopathy; respiratory failure or lung cancer from smoking; suicide attempts by drug overdoses; and morbid obesity.

"Critical care is costly and is under considerable review from a cost/benefit point of view," Dr Schnurr said.

"There have been suggestions that restrictions may have to be made on high-cost, low-benefit users such as the elderly, those with malignancies, and those with chronic respiratory failure.

"But is it appropriate for society to limit the amount of resources for critical care and suggest the elderly and those with cancer (be limited) when a large proportion of those now receiving such care are there because of lifestyle?"

He suggested more regulations might curb some of this demand for intensive care beds.

"Drinking and driving are not a good combination, but regulations are not as strict in Canada as they are in Sweden, for example, where the limit isn't 0.08%, but you lose your licence if you drink and drive, period. . . . To my mind, the alcohol and automobile problem is crucial.

"Smoking is more important economically, because it involves prolonged illness, but how do you convince people it's harmful?"

Lifestyle factors can never be used *per se* in making a decision about admission to an intensive care unit . . . Hospitals can't say "because you were drinking and got in an accident, too bad for you," Dr Schnurr said at the annual meeting of the Royal College of Physicians and Surgeons of Canada here.

But it must be society, "not doctors, governments, nurses, or hospital administrators" that decides where it wants to go in decisions about allocation of scarce resources.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000 ext 7384.

Everything Looks So Normal

Number: 628.
Subject heading: Employee assistance programs (EAPs).
Details: 28 min, color.
Synopsis: Drug abuse on the job costs business and industry $100 billion a year. Drug abuse is pervasive, common, and easy to conceal. One department in a company decides to look for and finds many problems related to drug use: an alcoholic using pills to get through the day until he can drink; a dealer in marijuana and his clients; women using tranquillizers with alcohol at lunch; an amphetamine abuser; a cocaine dealer and user. Action taken by the supervisor, including referral of some abusers for help, results in increased productivity in his department.
General evaluation: Good to very good (4.8). This contemporary, well-produced film had a clear message and was judged a good teaching aid. General broadcast was recommended.
Recommended use: With a resource person, could benefit supervisors and trainers in EAPs.

Straight Talk About Drugs: Stimulants and Narcotics

Number: 631.
Subject heading: Drugs: pharmacology, drug use: etiology and epidemiology.
Details: four filmstrips plus audio tapes, 10 min each.
Synopsis: This set of filmstrips contains two programs, one dealing with stimulants, the other dealing with narcotics. They both discuss what substances contain these drugs, and their effects. People who have used the drugs talk about their experiences.
General evaluation: Poor (2.1). These filmstrips were judged a poor teaching aid because of their scientific inaccuracies.
Recommended use: None.

Turnaround: A Story of Recovery

Number: 634.
Subject heading: Women and alcohol, women and other drugs, treatment/rehabilitation.
Details: 60 min, color.
Synopsis: Aurora House in Vancouver, British Columbia, is a residential treatment program for women with drug problems, including alcohol. Scenes of everyday activities are interspersed with other scenes of group and individual therapy sessions. The women discuss why they had used drugs, the effects on their lives, and their hopes for the future.
General evaluation: Poor to fair (2.7). The film was too long and did not give enough information about the actual treatment program.
Recommended use: Could be used with women contemplating treatment.

DEPARTMENT

New Books

by RON HALL

Dictionary of American Temperance Biography: From Temperance Reform to Alcohol Research, The 1600s to the 1980s

. . . by Mark Edward Lender

This book brings together historical data on 375 men and women active in temperance and alcohol research from the 1670s to the 1980s. Biographies tell of the lives of activists and their contributions to temperance history. Those selected for inclusion reflect the wide range of intellectual, ethnic, religious, and political opinion of temperance crusaders. Each biography begins with an outline paragraph providing dates and places of birth and death as well as basic data on education and careers. Additional information describes the person's connections with reform.

(Greenwood Press, 88 Post Rd W, Box 5007, Westport, CT 06881, 1984. 572p. $45. ISBN 0-313-22335-1)

A System of Health Care Delivery

. . . by Frederick B. Glaser; Helen M. Annis; Harvey A. Skinner; Shelly Pearlman; Ruth L. Segal; Barry Sisson; Alan C. Ogborne; Elizabeth Bohnen; Paul Gazda; and Torbin Zimmerman

This three-volume set constitutes a comprehensive account of every aspect of the work carried out in a project which sought to modify a model of health care delivery suggested for people with alcohol and other problems in another jurisdiction and apply it to the treatment effort of the Clinical Institute of the Addiction Research Foundation. Following a review of some basic conceptual issues, a multi-phase pilot project was carried out beginning in October, 1976. In phase I, the fundamental processes of primary care and assessment were separately implemented and studied. These two processes were then connected functionally with each other and with treatment programs for phase II of the study. Phase III considered the operation of the treatment system on weekends. These volumes have been prepared in order to deal with specific questions that have been asked by those planning to emulate the approach taken by the project. Included is detailed information on a basic assessment package, medical screening, computerization, and follow-up technology, as well as the functional dimensions of certain elements of the system. Aspects covered include: implementation of the system; medical and educational components; computerized information system; primary care; assessment; selecting patients for treatment; and follow-up.

(Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1. 1984. $30 [Set] ISBN 0-88868-093-7)

Other books

Getting Tough on Gateway Drugs — DuPont, Robert L. Jr. American Psychiatric Press, Washington, 1984. What is the drug problem; marijuana, alcohol, cocaine; how can families prevent and treat drug problems. 332p. Council on Drug Abuse, 56 The Esplanade, Ste 303, Toronto, ON M5E 1A7. $20. ISBN 88048-035-1.

Social and Medical Aspects of Drug Abuse — George Serban (ed). 1984. Biological influences on subjective states of addicts; opiate receptors and opioid peptides; conditioned taste aversions and regulation of drug-taking behavior; endocrine and immunological observations in heroin and methadone-maintained opioid addicts; behavioral factors in drug dependence and withdrawal; epidemiology of the current heroin crisis; social stress and drug abuse; psychiatric disorders in treated opiate addicts; narcotic antagonists; methadone maintenance. 244 p. SP Medical and Scientific Books, 175-20 Wexford Terrace, Jamaica, NY 11432. $40. ISBN 0-89335-191-1.

Your Teen and Drugs — Panzica, Norman. 1983. A parent's handbook on drug abuse; profiling the drug abuser; preventing drug abuse in the child; recognizing drug abuse; coping with teens on drugs; questions and answers; glossary of terms; suggested reading; index. 164p. McGraw-Hill Ryerson, 330 Progress Ave, Scarborough, ON $9.95. ISBN 0-07-548591-5.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:

a) Regular Line Rates	$1.09 line
b) Standard Units of Insertion	
1 Page (1,120 lines)	$1,000
½ Page (560 lines)	$500
¼ Page (280 lines)	$250

c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation: 27,318 (Canada, 21,412; USA, 1,907; Foreign, 386; Bulk, 3,613)
Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
USA & Foreign Residents: $24 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians

The Journal, 33 Russell St Toronto, Canada M5S 2S1

ISSN0044-6203 Printed in Canada

ARE YOU MOVING?

We don't want you to miss an issue of **The Journal**. You won't if you'll send us your new address and the mailing label from a back issue — promptly. Just write to: **The Journal**, c/o Marketing, 33 Russell Street, Toronto, Canada M5S 2S1.

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Murmurs of the Heart: Issues for Women in Medical Training — Feb 8-9, Toronto, Ontario. Information: Murmurs of The Heart, c/o Sherril Gelmon, Office of the Dean, Faculty of Medicine, University of Toronto, Toronto, ON M5S 1A8.

Drugs and the Mind: A Biological Perspective for Psychologists — Feb 13, Ottawa, Ontario. Information: Ontario Psychological Association, 1407 Yonge St, Ste 402, Toronto, ON M4T 1Y7.

38th Annual Convention of the Ontario Psychological Association — Feb 14-16, Ottawa, Ontario. Information: Dr Harvey Brooker, Convenor, OPA 85, 1407 Yonge St, Ste 402, Toronto, ON M4T 1Y7.

6th Annual Conference of the Canadian Association of Addiction Counsellors — Cross-Addictions — Feb 23, Toronto, Ontario. Information: Kathryn Irwin, 3253 Bathurst St, #B3, Toronto, ON M6A 2B3.

2nd Annual Symposium — Designing World Class Health Promotion Programs for Canadians — April 14-21, Burnaby, British Columbia. Information: Kros Cancer Society, 42 Begbie St, New Westminster, BC V3M 3L9.

Alcohol, Other Drugs and the Law Course — May 22-24, London, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation (ARF), 8 May St, Toronto, ON M4W 2Y1.

Parent Resources Institute for Drug Education (PRIDE-CANADA INC) 1st Annual National Conference — May 30-June 1, Saskatoon, Saskatchewan. Information: Ruth Kell, Convenor, PRIDE-CANADA, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

85th Annual Meeting of the Canadian Lung Association, and the Annual Scientific Meetings of the Canadian Nurses' Respiratory Society, and the Physiotherapy Section of the Canadian Lung Association — June 2-5, Ottawa, Ontario. Information: A. Les McDonald, health education coordinator, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, ON K1P 5E7.

International Convention of Alcoholics Anonymous — July 4-7, Montreal, Quebec. Information: International Convention, Box 1985, Stn D, Buffalo, New York 14210.

26th Annual Institute on Addiction Studies — July 14-19, Hamilton, Ontario. Information: Kathryn Irwin, course administrator, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer School for Addiction Studies — July 15-26, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-10, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

Royal College of Physicians and Surgeons of Canada — 54th Annual Meeting — Sept 9-12, Vancouver, British Columbia. Royal College of Physicians and Surgeons of Canada, Robert A. Davis, coordinator, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

The Canadian Thoracic Society and the Medical Section of the Canadian Lung Association, conjointly with the Royal College of Physicians and Surgeons — Sept 9-12, Vancouver, British Columbia. Information: A. Les McDonald, health education coordinator, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, Ontario K1P 5E7.

International Association of Forensic Sciences 11th Meeting — Aug 2-7, 1987, Vancouver, British Columbia. Information: International Association of Forensic Sciences, 801-750 Jervis St, Vancouver, BC V6E 2A9.

United States

5th Annual Betty Ford Center Conference on Alcoholism and Chemical Dependency: Women — Feb 17-20, Rancho Mirage, California. Information: Annenberg Center for Health Sciences, Eisenhower Medical Center, 39000 Bob Hope Blvd, Rancho Mirage, CA 92270.

Understanding and Working with Alcohol and Other Drug-Related Issues in the Older Population — Feb 18-20, Miami, Florida. Information: Joanne Terry, Johnson Institute, 510 1st Ave N, Minneapolis, Minnesota 55403-1607.

Interventions with Impaired Nursing Practice: The Perspective Nationwide — Feb 21-22, Kansas City, Missouri. Information: The American Nurses Association, 2420 Pershing Rd, Kansas City, MO 64108.

Adult Children of Alcoholics Round-Up — Feb 22-24, Orlando, Florida. Information: The US Journal, 2119-A Hollywood Blvd, Hollywood, FL 33020.

1st Annual Convention on Children of Alcoholics — Feb 24-28, Orlando, Florida. Information: Conference Coordinator/Disney, The US Journal, 2119-A Hollywood Blvd, Hollywood, FL 33020.

8th Annual Alcoholism Symposium, Strategies and Objectives for Treatment Interventions — March 9, Boston, Massachusetts. Information: Douglas Jacobs, director, continuing education division, The Cambridge Hospital, department of psychiatry, 1493 Cambridge St, Cambridge, MA 01239.

Developing a Student Assistance Program — March 11-12, Kenmore, Washington. Information: Hazelden, Box 11, Pleasant Valley Rd, Center City, Minnesota, 55012.

NECAD — Northeastern Conference on Alcoholism and Drug Dependence — March 24-27, Newport, Rhode Island. Information: Edgehill-Newport Foundation, Beacon Hill Road, Ste 106, Newport, RI 02840.

The National Nurses Society on Addictions — April 14-17, Arlington, Virginia. Information: NNSA, 2506 Gross Point Rd, Evanston, Illinois 60201.

National Council on Alcoholism 1985 Conference — Youth and Alcohol, Trends in Public Policies — April 18-21, Washington, DC. Information: Angela Heather Masters, NCA, 12 W 21st St, 7th fl, New York, NY 10010.

16th Annual Medical-Scientific Conference of the American Medical Society on Alcoholism — April 18-21, Washington, DC. Information: Louisa Macpherson, conference manager, AMSA, 12 W 21st St, 7th fl, New York, NY 10010.

The American Orthopsychiatric Association, Inc 62nd Annual Meeting — April 20-24, New York, New York. Information: American Orthopsychiatric Association, 19 W 44th St, Ste 1616, New York, NY 10036.

PRIDE's International Conference on Drugs — April 25-27, Atlanta, Georgia. Information: PRIDE, 100 Edgewood Ave, Ste 1216, Atlanta, GA 30303.

189th American Chemical Society National Meeting — April 28-May 3, Miami, Florida. Information: Dr M. H. Ho, department of chemistry, University of Alabama, Birmingham, Alabama 35294.

Central Region Conference of the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) — May 7-10, St Louis, Missouri. Information: Della Kinsolving, c/o St Elizabeth Medical Center, 2100 Madison Ave, Granite City, Illinois 62040.

16th Annual International Narcotic Research Conference — June 23-28, Seacrest, Massachusetts. Information: E. Leong Way, department of Pharmacology, University of California, San Francisco, California 94143.

36th Annual Conference of the Alcohol and Drug Problems Association of North America — "Confronting the Issues — Challenges for the 80s" — Aug 18-22, Washington, DC. Information: Eric Scharf, ADPA, 444 N Capitol St, Ste 181, Washington, DC 20001.

International Youth Services Conference — Oct 6-9, Chicago, Illinois. Information: Bill Treanor, executive director, American Youth Work Center, 1346 Connecticut Avenue NW, Ste 925, Washington, DC 20036.

National Federation of Parents for Drug-Free Youth, 4th Annual Conference — Nov 6-9, Washington, DC. Information: Mary Jo Green, NFP, 1820 Franwall Ave, Ste 16, Silver Spring, Maryland 20902.

Association of Labor-Management Administrators and Consultants on Alcoholism, 14th Annual Conference — Nov 10-14, Boston, Massachusetts. Information: Judith Evans, associate director, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

Association for Medical Education and Research in Substance Abuse, 9th Annual Conference — Nov 14-15, Washington, DC. Information: Dr G. Lewis, AMERSA president, Centre for Alcohol Studies, Brown University, Box G, Providence, Rhode Island 02912.

Abroad

International Symposium on Alcohol Problems — May 18-19, Madurai, India. Information: S. Selvin Kumar, Blue Cross Society of India, Palkalai Nagar, Madurai-21, India.

Scandinavian Study Tour on Drinking and Driving and Alcohol Policy — May 24-June 8, Oslo, Stockholm, Helsinki, Copenhagen. Information: Camilla Colantonio, department of Conferences, Nolte Center, 315 Pillsbury Dr SE, University of Minnesota, Minneapolis, Minnesota 55455.

31st International Institute on the Prevention and Treatment of Alcoholism — June 2-7, Rome, Italy. Information: International Council on Alcoholism and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

Social Work Goes to London — June 22-29, London, England. Information: Ann Boehme, Continuing Education Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, New York 11042.

International Youth Forum on Alcohol and Drugs — July 9-12, Cardiff, United Kingdom. Information: Dr Myrddin Evans, Addiction Unit, South Glamorgan Health Authority, Whitchurch Hospital, Whitchurch, Cardiff, CF4 7XB, United Kingdom.

1985 World Congress on Mental Health — July 14-20, Brighton, England. Information: Barbara Poole, World Conference Organizer, 22 Harley St, London, England W1N 2ED.

3rd International Conference on Alcohol and Drug Abuse — Aug 11-14, Lima, Peru. Information: L. Vasquez, International Education, Peruvian College of Physicians, Wadsworth, Illinois 60083.

2nd National Drug Institute — Alcohol and Drug Use in a Changing Society — Aug 14-16, Darwin, Northern Territory, Australia. Information: Chairman, NDI Planning Committee, Drug and Alcohol Bureau, Northern Territory department of health, GPO Box 1701, Darwin, NT 5794 Australia.

4th European Acupuncture and Alternative Medicine Symposium — 2nd World Symposium on Morathерapy and Lasertherapy — Aug 20-Sept 1, Copenhagen, Denmark. Information: Secretary General, Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

12th International Conference on Health Education — Sept 1-6, Dublin, Ireland. Information: Dr H. D. Crawley, director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

10th International Congress, World Conference for Physical Therapy — May 10-22, 1987, Sydney, Australia. Information: The Secretariat, 10th International Congress of WCPT, Australian Physiotherapy Association, PO Box 225, St Leonards, NSW 2064, Australia.

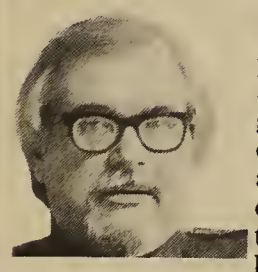
Cocaine now epidemic, says US researcher

'A million calls later'

In May, 1983, Arnold Washton, PhD, Mark Gold, MD, and colleagues at The Regent Hospital, New York, and Fair Oaks Hospital, Summit, New Jersey, opened the 800-COCAINE hotline. Response was instantaneous and greater than anyone would have imagined (The Journal, July, 1983).

The hotline provides an unprecedented picture of cocaine use and abuse in the United States: all of those questioned are self-referrals.

Dr Washton is director of substance abuse research and treatment, The Regent Hospital, and research director of the hotline. At the Southeastern Conference on Alcohol and Drug Abuse in Atlanta, he presented findings and observations gleaned from both callers to the hotline and patients in clinical programs. Contributing Editor, Harvey McConnell **reports.**



McConnell

As the 800-COCAINE national hotline approaches its second anniversary and its one-millionth caller, the evidence it provides is stark.

"It is clear that America is paying a very high price indeed for its continuing infatuation for mood-altering drugs — cocaine in particular. And I think it is fair to say that cocaine has become a cancer to our society," Dr Washton says.

He adds: "Perhaps one of the most frightening things about the cocaine epidemic is that it includes in its grip so many people in what we call 'critical job positions.'

"Callers to 800-COCAINE and patients who have shown up at our treatment facilities include airline pilots, air traffic controllers, railway switchmen, doctors, lawyers, school bus drivers, prison guards; the list goes on and on."

The fact that cocaine does not cause problems for everyone who uses it increases the danger of the situation because those who try it and don't become addicted proclaim the safety of the drug. At the same time, it is impossible to predict who will become an addict and who can use cocaine without problems.

"What's astonishing about this cocaine epidemic is that so many mature, stable, well-integrated people seem to become cocaine addicts," he adds.

Their findings from the callers to the hotline, all of whom undergo a 30- to 40-minute research interview, explode some of the myths and misconceptions held by both the public-at-large and specialists in the substance abuse field.

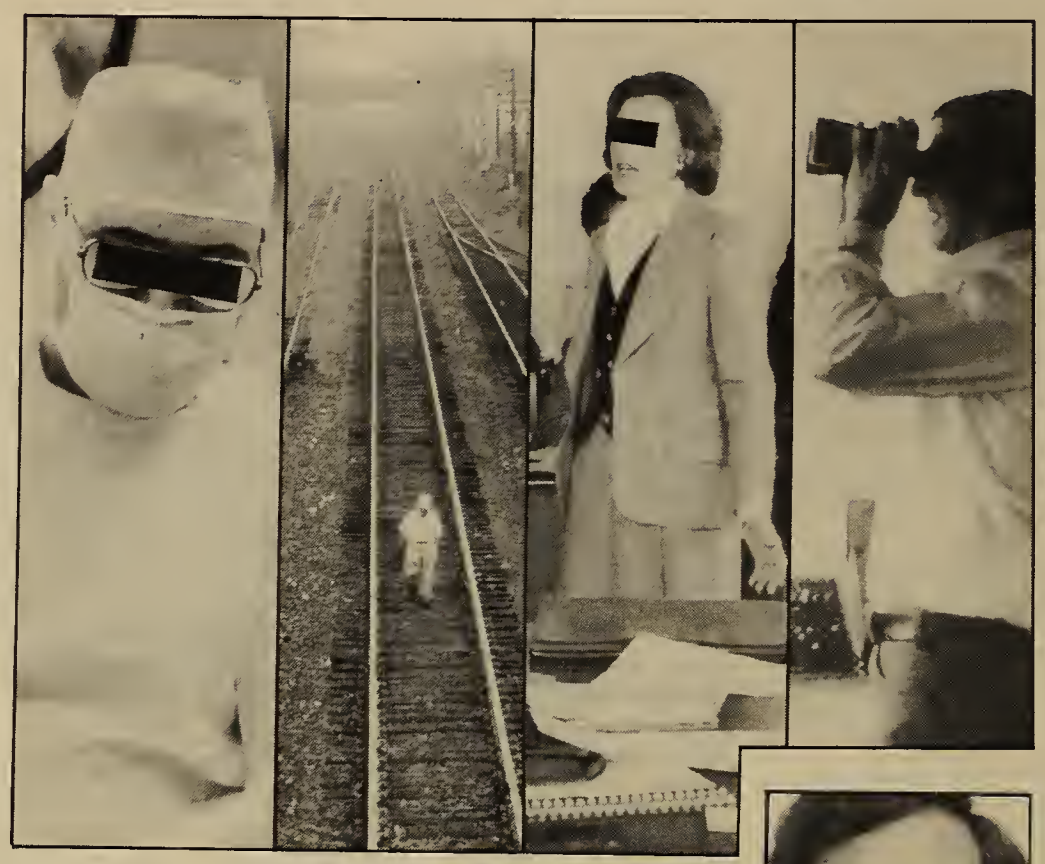
The most common, and dangerous, myth, Dr Washton finds, "is that if one snorts (inhales), one does not get addicted. Nothing could be further from the truth." A majority of patients at their treatment facilities are snorters.

A myth which can fool doctors and counsellors is the claim by cocaine abusers that they only use once a week, or two weeks, or even once a month. "It is a mistake to think of abuse and dependency only in terms of the amount or frequency of use — someone can be a once-a-month cocaine user and be an addict as well.

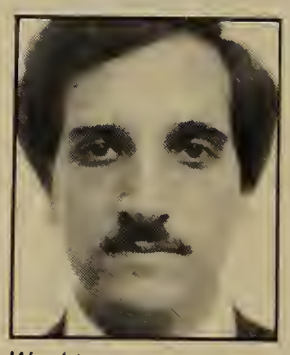
"Once-a-month" use can mean a three- or four-day run consuming between 10 grams and 15 g of cocaine.

Dr Washton said the doctor or counsellor must dig, and not be put off by the glib "I only use it once a month."

Cocaine addicts abuse other drugs, especially alcohol, which they use to try to control the depression which follows the cocaine high. "They become alcohol abusers and don't even know it, and when they stop the alcohol they get the shakes," Dr Washton observes.



Hotline calls: doctors, trainmen, lawyers, air traffic controllers . . . the list goes on



Washton

Most of the addicts are "treatment-naive," have never been in any program because they have never had a problem with any other drug, including alcohol, and most will not enter a treatment program unless it has "cocaine" in the title.

And, time and time again, callers to the hotline, after going through the research interview with one of the four counsellors who operate the phones 24 hours a day, and after painting a rather horrendous picture of what their life is like, will ask: "Doc, do you think I'm addicted? Do you think I have a problem? Do you really think I need treatment?"

They estimate that only about 20% of those who call will follow-up on treatment referrals which are provided to them.

The price of cocaine has dropped precipitously in the past year or so — at $60 to $70 a gram in many major cities it is cheaper than an ounce of marijuana (28.35 g) — and with it has come a rise in the number of women calling the hotline. Women now make up nearly 50% of callers.

As women generally make less money than men, this increase in their calling could reflect the drop in price of the drug. It means also it is now being made available to sectors of the population which, until now, could not afford it.

The abuser/addict profile they have developed is a fairly well-educated, 25- to 40-year-old individual, upwardly mobile, with a family and good job. Many are members of the "baby boom generation" who started on marijuana in the 1960s and graduated to cocaine in the 1980s.

Almost none has (been treated for) a previous drug addiction or any psychiatric illness.

Abusers report that cocaine makes them feel awake, euphoric, and at least 50% report that sexual stimulation is the major reason they become compulsive users. Many indulge in a "cocaine rap," or, as Dr Washton describes it, "a long, drawn-out, rapid, incessant discussion about absolutely nothing."

Alcohol seems a natural drug to seek to help mollify the dysphoric phase after the euphoric high. "If you run out of drugs or money, it is easy enough to get a bottle of wine, or a bottle of whiskey, and start medicating yourself." Eventually the user feels better and goes to sleep.

Dr Washton says that cocaine addicts, like those addicted to other drugs, are terrified of not having the drug. "I think this is one of the most curious aspects of all chemical dependencies — whether it is alcohol or other drugs: the fact that the chemically dependent person fears that things will be worse without their chemical of abuse, even though there is such obvious evidence that continued use is impairing their functioning. There must be some kind of cognitive process that gets disrupted, or even turned off, in the brain which would allow the chemical abusers to see reality for what it is."

The setting in which the drug is used is important. "It is not uncommon to find a user who is given supplies by business associates, even by an employer, who is himself a cocaine addict."

Dr Washton considers that, "in assessment, it is absolutely imperative to ask every cocaine user about other drug use, because most are self-medicating with alcohol or other drugs."

This will help determine if hospital detoxification is necessary. It is not necessary to get them off cocaine, "but because they have acquired a physical dependency on alcohol, sedative hypnotics, or opiates without ever realizing it, because they are not using them to get high but to self-medicate after cocaine use."

The main reason most cocaine addicts seek treatment is because they are hurting financially. "We have seen so many abusers who have liquidated assets, mortgaged their homes, cashed in stock and bonds, gone through their life savings."

Dr Washton and colleagues, as well as running the hotline, are in private programs which cater mainly to the cocaine abuser who is in business or a profession. Their clinical impressions are based on this sub-group. His own experience with substance abusers has included a position at a hospital in Harlem, New York, before joining The Regent Hospital.

Most patients are status-oriented and "it takes a lot of pride for them to walk in and admit they can't conquer their addiction problem on their own."

It has been popular to call cocaine abusers people with narcissistic personality problems. Dr Washton believes "in most cases it is more a result of the drug use itself than anything else. Cocaine makes you talkative; cocaine makes you overconfident; cocaine makes you full of crap, in most instances."

He and colleagues have developed a list of user types, and while some may seem to have comic overtones, they do represent people seen in practice.

The list includes:

- **Boredom relievers.** "For some reason life is not exciting enough. Cocaine provides that added sparkle, that thrill they don't seem to get in any other way."
- **Performance users.** These are people who find that cocaine appears to make them better at doing something. The hard-driving businessman may take cocaine before going into what he considers an aggressive sales meeting. "When high on cocaine his rap is much better, he feels. Often the people he talks to wind up thinking he is a grandiose idiot."
- **Excitement junkie.** These are thrill seekers in the extreme. If they were not using cocaine they would be sky diving, hang gliding, crashing up cars, "doing all sorts of life-threatening things because they happen to get off on putting themselves in jeopardy."
- **Disco addicts.** This is a phenomenon which has existed in big cities for some time and revolves around high-class discos where it is well-known cocaine is readily available. "People become addicted to the disco experience, and cocaine is part of the experience."
- **Tireless macho man.** "This is the guy who is out having endless sex with countless numbers of women, high on cocaine, because cocaine lets him do it."
- **The aging narcissist in midlife crisis.** "We are seeing a sub-group of cocaine users who are over 50 years old, who are in the midst of what appears to be a very serious midlife crisis, and who find that cocaine is the fountain of youth." One patient is a 62-year-old pharmacist who appeared for treatment with an open-chested shirt and gold chain. He was involved with 25-year-old women and convinced cocaine had put him back at least 20 years.
- **Self-medicator for sexual problems.** Someone with sexual problems will find an instant cure with cocaine, which is a lure of the drug. People with problems of impotence, or inhibited sexual desire, may find an instant cure. "Of course, what happens is, not too far down the road, the drug has the opposite effect and makes the problem worse."
- **Disenchanted marital partner.** A number of men approaching 40 have been married for 10 or fewer years, have small children, and have become disenchanted with their spouses. "They are 1960s generation people who felt they were never really going to grow old, that they were never going to settle down. Cocaine ends up getting coupled with numerous extramarital affairs."
- **Superman and Wonderwoman.** They are using the drug so they can fuel their workaholic frenzy. "They convince themselves they are absolutely capable of anything."

How do you determine if a cocaine addict needs to go in hospital? "All you have to do is ask them. Those cocaine abusers who require hospitalization, and know that they cannot stop using the drug on an out-patient basis, will tell you that.

"They know they have to go into hospital because they have made so many attempts to do it on their own, and with various forms of assistance, their compulsive craving is so strong they know they are not going to make it in out-patient treatment."

This is especially true of freebase (smoking) and intravenous users of cocaine. Most snorters can be treated on an out-patient basis, Dr Washton and colleagues have found.

Many patients have trouble accepting that they cannot return to social drinking since they could control their alcohol use before becoming addicted to cocaine. However, most abused alcohol when using cocaine, and drinking would also act as a cue for remembering cocaine use.

Dr Washton said their program must be on a no-holds-barred basis. "We will *not* allow our hands to be tied by a patient who comes in saying, 'I have a serious cocaine problem but I don't want my wife to know.' If the wife doesn't know, then they are handicapped in trying to recover."

If there is a cocaine abusing spouse involved, Dr Washton said, they require this person to either come in for treatment as well, or to submit voluntarily to urine screens to check any claim they have discontinued using the drug.

A fundamental of the treatment program is that the patients have constant urine screens, no matter how long they take part.

THE BACK PAGE

Vol. 14 No. 3 2nd Class Mail Reg No. 2776 TORONTO March 1, 1985

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

World drug demand, supply, and trade still on increase

Youth most at risk as traffickers forge on

By Anne MacLennan

VIENNA — More countries than ever before are reporting problems with illicit drug traffic. And most are drawing attention to the special vulnerability of their young people, says Tamar Oppenheimer, director of the United Nations Division of Narcotic Drugs here.

"Availability is more widespread, traffickers are more organized, there is little sign that illicit markets for most drugs are saturated," Mrs Oppenheimer told the opening meeting here of the 31st session of the UN Commission on Narcotic Drugs.

"By January 1985, 101 states and territories had recorded . . . that illicit drug traffic had been detected in 1983" (the year for which most recent final figures are available). She said it is "the greatest number ever in the history of the commission," and indications are the number will be even higher for 1984.

With increased drug supply and traffic, she said, many governments also estimate an increase in demand for illicit drugs — particularly among young people.

"Since 1985 is International Youth Year, it may be particularly opportune to note that a majority of those governments which report that drug abuse has been encountered identify youth as the group most at risk.

"A high proportion now indulge in the more dangerous types of multiple drug abuse often in conjunction with alcohol, volatile solvents, and other substances not under international control.

"This has been a major cause of growing concern during the last year," Mrs Oppenheimer told the Commission, the main policy-making body in international drug control. (The Division of Narcotic Drugs is the secretariat of the Commission.)

Mrs Oppenheimer said the deepening concern about increased availability of narcotic and psychotropic drugs is warranted in the face of the figures before the Commission.

Oppenheimer

They show that between 1982 and 1983, world opium and heroin seizures doubled, indicating a presumption of very considerable increases in illicit supply. In the same period, world cocaine seizures tripled to almost 40 tons

"In the case of cocaine, much of the increase in the quantity of drug seized was the result of improved, coordinated enforcement action, especially in the region of the Americas. However, there is also clear presumption of more illicit supply," said Mrs Oppenheimer.

Commission documents suggest cannabis and its preparations remain the drugs most widely trafficked and abused. Says one report: "The extent of continued expansion in traffic in this drug may be seen from the fact that the government of Mexico seized 8,000 tons in one, single, major operation in the autumn of 1984; this may be compared with more than 10,000 tons seized worldwide in 1983."

The document also notes that 62 governments reported detecting addiction to, or abuse of, opiates, including heroin, in 1983; that states through which heroin is trafficked are increasingly vulnerable to the spread of drug abuse; and that similar adverse impacts are reported by many governments with respect to cocaine (58 countries reported illicit traffic in cocaine in 1982).

The document adds that "many government reports reflect the geographical spread of drug abuse from larger cities and towns into smaller urban locations and into rural areas, with adverse consequences to individuals, families, communities, and entire societies, including the impairment of physical and mental health, a marked increase in criminal activities, and other significant social costs."

Attending the meeting were delegates from 40 member states, including Canada, as well as observers from some 30 other countries, and from a wide range of regional governmental bodies, intergovernmental organizations, such as the International Criminal Police Organization, specialized agencies, and non-governmental bodies concerned with drug abuse.

WHO now tackling cocaine, speed

By Harvey McConnell

GENEVA — An inexorable spread of cocaine around the world and a flooding of Africa and the Middle East with amphetamines are current major concerns of World Health Organization (WHO) drug experts.

It is an ironic twist: during the past 30 years the WHO has had a major role in helping many poor countries start to conquer centuries-old endemic diseases. Today it is being called upon to help them face new diseases: alcohol and other drug abuse.

Cocaine trafficking is now so well organized that the drug is turning up in countries in Southeast Asia, the centre of much of the world's illicit heroin production.

And, while British and West German pharmaceutical companies legally manufacture amphetamines for clinical use, they throw up their hands in shock at any suggestion their products are among the millions of tablets being sold cheaply in much of Africa and in the Middle East — in Saudi Arabia and Iraq in particular.

WHO today —See p 9

Awni Arif, MD, senior medical officer of the WHO's Drug Dependence program, says the agency is developing policies and strategies it will present to member nations in a bid for more concerted international action against cocaine trafficking and use.

He has no doubt: "Cocaine is more dangerous than heroin and I don't think any society is immune to cocaine use. It is the most reinforcing drug in existence."

At the turn of the century, cocaine use rose and fell. Today is different: "There is massive production of cocaine, it is much more widely available. It is even cheaper than heroin in some areas, and it is easy to move," he added.

"The current low price of cocaine will create a new generation of cocaine users," Dr Arif told **The Journal**. Illegal production is well organized in the Andean countries by a multibillion dollar organization which is also transporting and marketing the drug.

Efforts must be made in every country to cut down the demand for drugs, but the main emphasis now, especially with cocaine, is to go after supplies, he said. This may be easier against the coca bush as it is still confined to South America.

As for the amphetamines flooding into Africa and the Middle East, Inayat Khan, MD, PhD, senior medical officer in the WHO's division of mental health and an expert on psychotropic drug use, says that in many countries in Africa they arrive by the planeload during harvest time. They are used to get more production from the farm workers.

Dr Khan told **The Journal** that as secretary of a WHO expert committee considering amphetamine use, it is difficult for him to speak freely about the situation. He acknowledges, however, that despite denials of diversion, the amphetamines being seized have exactly the same structure as those produced by the West European pharmaceutical companies.

DEA threatened as cocaine wars escalate

Valentine posies cover smuggling operation

By Harvey McConnell

WASHINGTON — Officials of the United States Drug Enforcement Administration (DEA) are taking very seriously reports that Colombian drug traffickers are willing to pay $350,000 and up for the kidnap of top DEA officials.

At the same time, US officials seized more than one ton of cocaine hidden in a shipment of Valentine's Day flowers in an Avianca 747 flight from Bogota, Colombia. The seizure confirms claims by US growers that flowers are being dumped on the US market as a blind for smuggling cocaine (**The Journal**, Aug 1984).

Robert Feldkamp, a spokesman for the DEA, told **The Journal**: "We have got an intelligence report from Colombia (on kidnap threats against DEA officials), and they have essentially been confirmed from Hispanic sources in this country in at least four states, and the threat is very real."

Asked why the Colombians would wish to capture the DEA administrator Francis Mullen Jr or other top officials, as reported in the Feb 25 issue of *Newsweek*, Mr Feldkamp said: "Who knows?

"They may be wanting to make a point, they might be wanting to hold them for an exchange for some Colombians we're holding, or simply to retaliate against the law enforcement successes which have been made against them in Colombia. Who knows?"

Security has been tightened not only in the DEA offices in midtown Washington but also in DEA offices around the country.

Mr Feldkamp said that a DEA agent had been kidnapped in Mexico. The agent had been investigating, among other things, a strong and dangerous cocaine ring in the Guadalajara area run by Mexicans with Colombian connections. "We suspect his kidnapping is related to that."

Media concern

The US government put pressure on the Mexican government to find the agent.

In addition, Mr Feldkamp said, there is "no question" that flower shipments from Colombia are being used to bring in cocaine. In Miami, an Avianca jet was found to have 2,478 pounds of cocaine hidden among Valentine's Day flowers. The Boeing 747 was seized by US Customs but later released to the Colombian airline after talks between the US customs service and Colombian government officials here.

Avianca put up $1 million and a promissory note of $983,400 to get

(See — **Kidnap** — page 2)

INSIDE

NEWS

Briefly ...

Boycott threatened

REYKJAVIK — Smokers here are facing a double threat as the government institutes Europe's most stringent anti-smoking laws, and cigarette manufacturers threaten to retaliate with a boycott. Iceland must import all tobacco products, and international companies are angry about a government plan to force them to cover the fronts of packages with large health warnings, including illustrations of smoking dangers to specific body parts. Label changes have been postponed until July 1, but smokers face bans in most public places, including post offices, banks, and any building housing a nursery or school, as well as all public transportation including internal airline flights.

Gambling study

TORONTO — A $25,000 contract to study the social effects of compulsive gambling has been awarded to The Canadian Foundation on Compulsive Gambling (Ontario). The Foundation was established in 1983 to increase public awareness of pathological gambling. The grant from the provincial ministry of community and social services will assist development of treatment programs and dissemination of information, reports *The Medical Post*.

Tough rules urged

LONDON — The House of Commons transportation committee here is recommending stricter breath tests, lower blood-alcohol levels, and an urgent study of the role of other drugs in accidents. *The London Sunday Times* reports that the all-party committee also proposes more campaigning against drinking drivers and not just at Christmas. They have also called for clearly labelling drugs that can impair driving ability. At the same time, the committee recommends more stringent annual vehicle inspections and regular eye tests for drivers.

Scotch whisky glut

LONDON — Economic problems in many parts of the world have led to a surplus of Scotch whisky and forced the closing of 10 distilleries this month by Britain's biggest whisky-maker. Scottish Malt Distillers Ltd, a subsidiary of Distillers Co P.L.C., said sales expectations for the next few years have dropped and, since whisky spends years in the cask maturing, production levels must be planned years in advance.

Tobacco 'tea bag'

LONDON — Health authorities here are calling for a ban on television advertising of "tobacco tea bags," and for the products, marketed as "Skoal Bandits," to carry health warnings similar to other tobacco products. In a pilot campaign in the Liverpool area, the tea bag is being billed as "a new way to enjoy tobacco," or "tobacco satisfaction without lighting up," reports *Medical News*. The main advantage, says US Tobacco International Inc, which imports the product, is convenience — the accessibility of smokeless tobacco at times when smoking is prohibited or inconvenient.

Prior consent proposed for drivers

MDs concerned about blood-test suits

OTTAWA — Doctors who take blood samples from unconscious drivers believed to be impaired should be given full protection under the Criminal Code from civil law suits, says the Canadian Medical Association (CMA).

In a brief to the federal House of Commons Committee on Justice and Legal Affairs, CMA representatives said doctors should put the public good (of reducing impaired driving) above the interests of individual patients.

But to do that, doctors must be given protection from civil suits which may be brought by patients, said Doug Geekie, a spokesman for the CMA.

Mr Geekie said legislation protecting both doctors and hospital staff is already in effect in Alberta, Saskatchewan, and Manitoba.

But, under the present system, a doctor can refuse to take such a sample if it will endanger the patient's health.

"It does specifically put the professional in a special situation, but the drunk-driving question is so darn serious, we've got to do everything we can to solve it," Mr Geekie told **The Journal**.

He said if such an amendment to the Criminal Code were enacted, it would mean that doctors who refused to take such samples from patients could be charged with impeding justice.

The CMA representatives told the committee the need to take stronger action against impaired drivers is becoming more evident. In Canada in 1983, there were 3,623 motor-vehicle accidents which led to 4,209 fatalities, and 157,000 accidents which caused 224,304 injuries. In nearly 50% of the fatal accidents, and more than 25% of those which caused injuries, alcohol was a contributing factor, the brief said.

Mr Geekie said the committee questioned the CMA representatives for about 2½ hours. He said the committee seemed especially interested in a proposal, also suggested in the brief, which would compel all drivers to sign a release form, when applying for or renewing a licence, allowing a blood sample be taken from them if required.

Mr Geekie said this would require legislation to be enacted in every province since drivers' licences are a provincial responsibility.

But Lloyd Bartlett, MD, a spokesman for the Manitoba Medical Association, said such a proposal was made in Manitoba about 10 years ago. He said legal opinions offered suggest that such a system could not stand up to court challenges since an individual cannot be forced to sign away a basic right.

Teens more aware of alcohol, cocaine risks

By Terri Etherington

ANN ARBOR, Mich — A shift in attitudes may be one reason for the continuing, gradual decline in illicit drug use among United States youth.

Teens may be becoming more concerned about the consequences of being heavily involved in substance abuse, and more interested in their career and academic goals, says Lloyd Johnston, PhD, senior researcher for the annual University of Michigan nationwide survey of highschool seniors.

The most significant trend in the 1984 survey was the continued decline in the number of daily marijuana smokers, Dr Johnston told **The Journal**.

Last year, 5% of highschool seniors reported smoking marijuana regularly (20 times or more in the month prior to the survey), compared with 5.5% in the 1983 survey (**The Journal**, March 1984).

The drop is part of a "dramatic change" which has seen the number of daily marijuana smokers drop by more than one-half since the peak of 11% recorded in 1978.

Perhaps more importantly, he told **The Journal**, nearly nine out of 10 students said they disapprove of regular marijuana use, and two-thirds see regular use as entailing a "great risk" to the user.

Concern about the adverse effects "has resulted in an increasing number of young people terminating or reducing their use after some initial period of involvement. Substantially fewer are finding themselves surrounded by friends who are users," Dr Johnston said.

"This substantial downturn in use of marijuana, in the face of continuing, widespread availability, illustrates the critically important fact that drug abuse can be dealt with effectively through reducing demand for drugs, not just the supply."

Attitude shifts have been slower "catching up" to heavy drinking among highschool seniors, says Dr Johnston.

For the first time, however, "we've seen a drop in the measure of occasional heavy drinking (five or more drinks in a row). It is a particularly troublesome statistic because it says that something in the order of 40% of the age group are getting drunk once every two weeks at least."

Of the 17,000 seniors in 140 public and private highschools surveyed, 72% reported using alcohol in the month prior to the survey, 5% reported drinking daily, and 39% reported occasional heavy drinking.

Cocaine

Cocaine use among young people continues to be a concern, Dr Johnston said, although prevalence of use in the month prior to the survey remained level at about 6%. This, Dr Johnston pointed out, is still the peak level for cocaine use since the surveys began in 1975.

He said there was a "statistically significant increase in cocaine use in the northeast (US)," but he and colleagues Jerald G. Bachman and Patrick M. O'Malley caution that it is too early to detect a definite shift in trends in that area. He said the increase in the northeastern states is offset by declines in other areas of the country.

However, Dr Johnston said, as with marijuana and cocaine, students are beginning to perceive a greater risk in the use of cocaine.

"I would view that as a kind of natural correction process where young people, over time, become more aware of risks of a particular drug and, as a result, are less likely to use it. I think we've seen that historically for LSD and PCP, and for heavy marijuana use, and now I think we may be at the beginning of seeing that for cocaine. I certainly hope so."

Johnston

The survey showed that lifetime, annual, and monthly prevalence rates for cocaine use among the class of 1984 are 16%, 12%, and 6% respectively.

Dr Johnston said more students are getting into difficulty with the drug. "I think that we have really a very troublesome level of casualties resulting from cocaine use at the present time. Casualty statistics have been rising and continue to rise."

Cigarettes

Another significant trend in the survey, which was conducted for the US National Institute on Drug Abuse, was the renewed decline in cigarette smoking.

Dr Johnston said that after a sharp decline in the number of teen smokers between 1977 and 1980, the statistics levelled out in the past three years . . . . "That gave us some concern that we were about to see a reversal of the previous decline."

But, in the class of 1984, 18.7% reported daily smoking compared with 21.2% in 1983.

Other drugs

The survey also showed continuing, gradual declines in the nonmedical use of stimulants, sedatives, and tranquillizers.

The percentage of students who reported use of sedatives or tranquillizers in the month prior to the survey was only about half the peak rates recorded in the 1970s. Stimulant use is down somewhat less from its peak level in 1981.

The use of LSD continued a decline begun three or four years ago, while PCP use remained at a low level after a precipitous drop in use between 1979 and 1982.

Use of heroin and other opiates remained stable between 1983 and 1984, though at somewhat lower levels than in earlier years, the survey reports.

Inhalants were the only category of drugs to show an overall increase among students. Prior year use rose to 8% in 1984 from 7% in 1983. However, Dr Johnston said, other prevalence-of-use statistics for this class of drugs remained stable.

The overall proportion of seniors who have ever tried an illicit drug fell slightly to 62% in 1984 from 65% in 1983.

Dr Johnston said that while it is "important to recognize that a growing number of youth are showing common sense and good judgement when it comes to alcohol, cigarettes, and illicit drugs," he would caution against complacency.

"We still have an exceptional number of our youth involved in patterns of substance abuse which are harmful to them, harmful to their families and friends, and certainly harmful to society as a whole. And, as cocaine has so vividly demonstrated, we are not immune to new national epidemics, nor to local epidemics of particular substances."

Governors want military to intercept traffickers

WASHINGTON — Governors of five southern, gulf-coast states have called on Congress to change the law so the United States military can help intercept drug traffickers.

At the same time, the five governors, meeting at a "Southern Summit" here, discussed the idea of invoking the death penalty for large-scale smugglers. There is large-scale trafficking of cocaine and marijuana from Latin America into the gulf-coast states.

Governors Edwin Edwards of Louisiana, George C. Wallace of Alabama, Mark White of Texas, William Allain of Mississippi, and Robert Graham of Florida called on Congress to pass new laws which would specifically allow the armed services to search out and capture drug smugglers.

In Washington, a spokesman for the department of defense said that the military at the moment is doing as much as it can to help under the strictures of current laws.

Kidnap threat

(from page 1)

its plane back. However, the airline faces penalties which could run as high as $50 for each ounce of cocaine seized.

The US state department recently warned US citizens living in Colombia that they should take the utmost care in security because of the increased possibility of violence. Following the kidnapping of the DEA agent in Mexico, the US customs service was asked by Washington officials to intensify its searches at all Mexican border crossings.

The current law enforcement push and battles among the cocaine traffickers themselves in Colombia, Latin America, and the US are featured in the Feb 25 issues of both *Time* and *Newsweek* magazines.

NEWS

Princess' lung op may end royal warrants for cigarettes

By Alan Massam

LONDON — Britain's tobacco industry has suffered a major psychological setback — the threatened withdrawal of the so-called royal warrants granted to manufacturers whose products are used on royal estates.

The "review of warrants" was announced by the Lord Chamberlain and is clearly linked with the recent lung operation performed on the Queen's sister, Princess Margaret.

Margaret has been a heavy smoker for many years. She had a section of one of her lungs removed at the Brompton Hospital here, and surgeons later announced that the tissue was "innocent." The Princess left hospital after one week and departed for convalescence in the Caribbean early in February.

Health educators have protested about the royal warrants on cigarette packets — allowing the manufacturers to print the royal coat of arms under the words By Appointment — for many years, but it seems that Princess Margaret's illness finally convinced the Queen that she would be justified in taking action.

Princess Margaret: convalescing

The Lord Chamberlain's announcement followed a protest about the warrants in the House of Commons by a Member of Parliament (MP) for Hackney-North and Stoke-Newington (an East London constituency), Ernie Roberts.

It said that the (by appointment) endorsements would be reviewed firm by firm as a matter of urgency.

Mr. Roberts said later he hoped the warrant would disappear from all cigarette packets. "I assume that account will be taken of the concern of both MPs and the British Medical Association (BMA) about the considerable loss of life due to smoking," he said.

Renee Short, chairman of the Commons Select Committee for Social Services, endorsed Mr Roberts' view. She said: "The whole medical profession will be absolutely delighted as will the Royal College of Obstetricians and Gynecologists, who are very concerned about expectant mothers smoking."

As far as is known, Princess Margaret is the only member of the Royal Family who smokes. Among manufacturers who display the royal warrant are Dunhill, Benson and Hedges, and John Player.

One of the most energetic campaigners against the granting of royal warrants has been Tom Hurst, director of the National Society of Non-Smokers. He said: "I first suggested these warrants should be withdrawn about 10 years ago and have repeated my appeals several times since.

"Naturally we are all very pleased that this is now going to be reviewed. The royal endorsement must have seemed to many as a personal mark of approval by the Royal Family. This could only be a barrier to the efforts of health educators."

Meanwhile the BMA is stepping up its campaign to get all tobacco advertising and sponsorship banned.

Officials from the association have been involved in talks with sports minister Neil MacFarlane, about the widespread sponsorship of sporting events by cigarette manufacturers. They say the sponsorship defies the spirit of the voluntary agreement between the government and manufacturers, under which they undertake that their products should not be associated with health, youth, or success.

A recent study surveying secondary school children's awareness of cigarette brands found that they had most knowledge of brands made by firms which were most frequently sponsoring sports on television. Sports sponsored by tobacco companies on British television include bowls, football, golf, motor racing, motor rallying, motorcycling, racing, rugby league, rugby union, snooker, and tennis.

Cdn tobacco sponsorship policy leaves athletes pondering future

OTTAWA — Pressure from Health and Welfare Canada has been held to be largely responsible for a change in government policy which will phase out tobacco-company sponsorship of amateur sports associations.

And, while anti-smoking lobby groups are naturally delighted by the new policy announced by Amateur Sports and Fitness Minister Otto Jelinek, the sports groups themselves continue to be concerned with the financial impact and future implications of the decision.

Jelinek

Epp

In January, Mr Jelinek announced a "fair and equitable" solution to the controversial issue of tobacco-sponsorship in amateur sports which has dogged both this and the earlier federal government since last year. That controversy was set off when RJR-Macdonald announced a five-year, $1.7 million agreement with the Canadian Ski Association to sponsor national championships in alpine, ski-jumping, free-style, and nordic events (**The Journal** Jan, March, 1984).

Under the new policy, current tobacco sponsorship agreements will be allowed to run their course but will be prohibited after they expire.

The policy was a reversal from statements made by Mr Jelinek last year in which he indicated tobacco sponsorship would not be stopped. A Progressive Conservative policy paper prepared last summer also favored allowing tobacco companies to sponsor amateur sports associations and events.

People involved in the talks which preceded the announcement of the new policy told **The Journal** that Health and Welfare Minister Jake Epp was heavily involved in instituting the new policy.

One source said Mr Jelinek was "squeezed into a corner" on the issue, while another unidentified source, who predicted the new policy weeks before it took place, said that "a certain amount of political gameplaying" was involved.

"It would be very nice for Mr Jelinek if he could appear to be . . . the minister who fought for the interests of big business but was over-ruled."

At the press conference, Mr Jelinek said he had been convinced about the harmfulness of tobacco but felt it was "unwise to tamper with contract obligations."

Asked about any inconsistency in the policy which does not touch on sponsorship by the alcohol industry, Mr Jelinek said he was following a Health and Welfare position that consuming alcohol in moderation is not harmful.

While no specific penalties were spelled out against organizations which may ignore the policy, amateur sports groups have been waiting to receive written details on the policy, and Mr Jelinek has indicated groups could be cut off from federal funding if they do not cooperate. The federal government currently provides about $60 million annually for fitness and amateur sports.

A spokesman for the Sports Federation of Canada, which represents 68 amateur sports groups, said the groups were to be polled on their feelings about the new policy as soon as the guidelines appear in writing.

Acting executive-director of the group, Katherine Elliott, said that in early surveys of the groups the response was almost unanimously opposed to any move to end tobacco-company sponsorship.

Ms Elliott said the feeling was that any private funding that could be obtained was legitimate.

The amateur sports groups have another concern as well. Ms Elliott said that even though Mr Jelinek has assured the groups that the policy will only affect tobacco companies, they fear that liquor-company sponsorship may be threatened in the future.

The involvement of tobacco companies in the sponsorship of amateur sports in Canada is currently confined to just a few sports — skiing, yachting, windsurfing, and equestrian events — and has totalled an estimated $10 million annually in recent years.

Innuendo sways the court of public opinion

By Wayne Howell

"Who put the overalls in Mrs Murphy's chowder
Nobody answered so they shouted all the louder—
WHO PUT THE OVERALLS IN MRS MURPHY'S CHOWDER . . ."

This is all I can recall of an Irish folktune I knew when I was very young. I imagine that the recursive nature of the song, which allowed the singer to increase the volume incrementally, was what appealed to me as a child and why I remember at least a fragment of it to this day.

In any event, it seems an appropriate epigraph for a discussion of the "Hatfield Affair," because as I write this, no one knows who put the pot in Premier Richard Hatfield's suitcase, despite the fact that there has been a lot of shouting by various politically-motivated "McCoys" out to get not only Hatfields, but MacKays, Crosbies, and Mulroneys as well.

Hysteria seems to be the order of the day when one discusses the Hatfield affair; even people with only a peripheral involvement — such as Judge James Harper — have ended up doing and saying intemperate things.

Let us look objectively at some of the things that have caused so much distemper. Various opposition members of parliament (MPs) have been scandalized by the fact that the Royal Canadian Mounted Police compromised the entire investigation by not seizing Mr Hatfield's suitcase as evidence at the moment the marijuana was found. But surely this was a case for situational police ethics; one looks at the glory of a high-profile "dope bust" and one looks at the international embarrasment that might ensue (Hatfield toasting the Queen in jeans and sneakers because the Mounties snatched the suitcase containing his tux), and one opts to forgo usual police procedure because of higher occasions of state.

Do we need a special parliamentary investigation of this incident? Consider what would have happened if the Mountie had not exercised discretion; Mr Hatfield and the Queen would have been publicly embarrassed and the British tabloid press (which has been out to get Hatfield ever since his famous "Lady Di" speech) would have had a field day. Canada and its police force would become the laughing stock of the world. And the Mountie who caused all this would not be looking forward to a medal from a grateful nation; he would be looking forward to a 5-year stint in the high Arctic, if he were not looking forward to the unemployment commission line.

The pre-charge meeting between Solicitor-general Elmer MacKay and Mr Hatfield has been cited as evidence of "collusion and cover-up" at the highest level — one law for the rich and powerful, one for the poor, and so on. Now granted, the New Brunswick chap who was recently convicted for marijuana possession because he had "marijuana breath" did not, apparently, have any opportunity to discuss his halitosis problem with the Solicitor-general (**The Journal**, Dec, 1984). So we definitely have to keep an eye on this kind of thing.

But let us look at Hatfield's situation. He was not "Joe Blow from Komoko" to use Judge Harper's expression. Unlike Joe Blow, he could easily afford the loss of $100 or so a conviction would entail. It was not that loss that concerned Mr Hatfield, it was the loss of his political career, which could easily occur just because a charge was laid. (The court of public opinion — the supreme court that pronounces judgment on all elected officials — is notorious for its lack of recognition of due process and the like.)

Furthermore, the evidence the police had against Mr Hatfield was not enough to warrant the laying of a charge against "Joe Blow from Komoko:" they couldn't prove Mr Hatfield put the pot in the suitcase; they couldn't prove the suitcase had not been handled by anyone else; and despite the use of sophisticated laser technology, they could not identify the prints on the pot-bag as the premier's. Given this situation "Joe Blow from Komoko" would not have been charged; as a matter of fact it is highly unlikely that "Tom Trafficker from Toronto" would have been charged. (Tom Trafficker would not have to dip into his "contingency fund" for high-priced legal counsel to beat a rap like that; he could beat it with an articling student working for Legal Aid.)

It would appear that the only reason Mr Hatfield was charged was because the leak regarding the incident had put both the Mounties and the justice department in a "Catch 22" situation not unlike Mr Hatfield's own. They knew they couldn't win if they laid a charge, but neither they nor Mr Hatfield could ever get clear of the matter if they didn't lay a charge — they would have been the subject of endless innuendo of the "one law for Joe Blow, one law for Disco Dick" variety.

Given all this, I think opposition MPs who see some sort of "Watergate coverup" in the meeting between the Solicitor-general and the Premier of New Brunswick are either genuinely hysterical, or are cynically playing to the paranoid fantasies of certain elements of the press and public. Needless to say, the latter is the more likely possibility.

NEWS

'Our social conscience has been twigged'

Restaurant rewards sober drivers so others may indulge

By Tim Padmore

VANCOUVER — A restaurant's fattest profits come from sales of liquor.

Stung by criticism that those profits come at the expense of people hurt by drunk drivers, the Restaurant and Foodservices Association of British Columbia is pushing a so-called designated driver program.

The basic idea is that the restaurant offer free, non-alcoholic drinks and other benefits if one person in a large party agrees to limit alcohol consumption.

So far only one restaurant, The Keg, of Nanaimo, has seriously tried the idea.

The promotion was modestly successful in keeping drinking drivers off the road — about 20 groups in the first month of operation around the Christmas season took advantage of the offer.

It was a huge success in terms of publicity for the restaurant, drawing extensive coverage in the local media and favorable editorials.

Nanaimo Keg owner-operator Warren Erhart told **The Journal** revenues were untouched. Perhaps because the other diners felt more free to indulge, "the average cheque per customer was not decreased at all." It was also, he said, good for staff morale.

Dunc Holmes, vice-president of communications for The Keg restaurant chain, which has more than 90 restaurants in Canada and the United States, said he is in favor of extending the idea through the chain.

"We would never want people to stop drinking. That's our business . . . (but) our social conscience has been twigged."

In Nanaimo, the designated driver for a party of eight or more gets a "No Drinking" button, free soft drinks, and a $10 meal gift certificate.

Mr Holmes said that the party of eight requirement may be too high and is being reviewed.

Don Bellamy, head of the 1,200-member Restaurant Association, said the association has sent out 1,000 kits at a cost of about $4,000 to member restaurants and Royal Canadian Mounted Police detachments in the province.

"We've always been getting a black eye because (people say) we like to shove booze at people, and that's not true," he said.

"If we expect to get any concessions in liquor (regulation) we, as an industry, have to be prepared to take some measures ourselves."

Mr Bellamy said there is interest in the BC program from the US, where the National Restaurant Association has been studying the idea, and he has forwarded material on the program to Detroit restaurateurs.

To all Employees:

Our Policy Regarding Guests Who Consume Alcoholic Beverages

1. We will let no guest leave our restaurant intoxicated with the intention of driving. This may mean calling a cab (at our expense), or providing some other form of transportation.
2. We will immediately stop serving additional alcoholic beverages to anyone who exhibits signs of intoxication such as:
   - ○ Slurred Speech
   - ○ Belligerence
   - ○ Foul Language
   - ○ Loss of Coordination
   - ○ Loud Speech
   - ○ Being a Nuisance
   - ○ Irrational Statements
   - ○ Glassy Eyes

3. The manager on duty must personally handle all liquor related problems with our guests. This includes any situation where a guest must be "cut off."

We ask for your support in helping us to manage a responsible liquor operation.

Restaurant & Foodservices Association of BC Member

RESTAURANT & FOODSERVICES ASSOCIATION OF BRITISH COLUMBIA
#210 - 3369 Fraser Street, Vancouver B.C. V5V 4C2
DWI CAMPAIGN

Employees' guide: BC restaurateurs' policy for drinking patrons

RESEARCH UPDATE

Testing for early pancreatic lesions

Testing of a method to detect abnormalities of the pancreas has shown both that the technique is valuable for detecting early lesions induced by alcohol, and that asymptomatic pancreatitis is frequent in chronic alcoholism. The Italian study used endoscopic retrograde pancreatography, a well-tolerated, low-risk invasive procedure, to detect possible early pancreatic lesions in 35 patients with chronic alcoholic liver disease but without evidence of pancreatic disease. All patients had ingested at least 100 grams of alcohol daily for five years. The researchers at the gastroenterology unit of the 3rd Medical Unit, Milan, found that 42.9% of the patients tested showed changes suggesting mild chronic pancreatitis and an additional two patients had advanced disease. All 10 patients with alcohol intake reported to be higher than 200g per day had pancreatic lesions. The severity of pancreatic damage did not correlate with the degree of hepatic changes, the researchers said, suggesting that parallel but independent processes were responsible for the ethanol-induced lesions. The study concluded that the diagnostic procedure may be useful for detecting minor pancreatic lesions not otherwise demonstrable in chronic alcoholics.

Journal of Clinical Gastroenterology, Dec 1984 v.6:519-523

Male quit rates overstated?

The accepted concept that women find it harder than men to give up smoking is not supported by available evidence, says a British researcher. Martin Jarvis of the Addiction Research Unit, Institute of Psychiatry, London, said that both the United States surgeon-general and the British Royal College of Physicians in recent years have lent authority to the belief that women have more difficulty stopping smoking. But, Dr Jarvis argued in his study, earlier findings have failed to take into account that many men switch to other tobacco products when they give up cigarette smoking. Using 1982 British census data, Dr Jarvis showed that the prevalence of men and women cigarette smokers in the general population was 38% and 33% respectively and these rates rise to 43% and 34% when those who have switched from cigarettes to cigars are taken into account. Similar substantial differences are seen in cessation rates, he said, dropping to 32% from 44% in men aged 35 to 49 years, and to 40% from 48% in men aged 50 to 59 years, when secondary cigar smoking is taken into account. As few women take up cigar smoking, Dr Jarvis said, their cessation rate hardly changes, and much of the apparent difference in quitting rates disappears. An examination of two US national smoking surveys shows the same change, he said, with the difference in cessation rates being reduced to 5% from 11%. Because such surveys do not usually take into account other forms of tobacco use, such as pipes, snuff, and chewing tobacco, Dr Jarvis said male cessation rates would probably be even further reduced. He concluded that "claims of a sex difference in ease of cessation should at present be regarded as quite unproven."

British Journal of Addiction, Dec 1984, v.79:383-387

Blood components change

A Finnish study showing changes in certain components of the blood of alcoholics seen during detoxification may help explain why alcoholics are more susceptible to various thrombotic diseases. Researchers took blood samples from 10 healthy volunteers and 10 alcoholic males with normal blood pressure admitted to an in-patient program for detoxification. Because the blood make-up was being measured, alcoholic patients who might have had abnormal platelet behavior for reasons other than prolonged ingestion of alcohol were excluded from the study. Blood samples were taken from the alcoholics at one, seven, and 14 days after admission and all had been abstinent for three days prior to admission. At admission, six of the alcoholics had thrombocytopenia (a decreased number of blood platelets) and the platelet count for the whole group was significantly less than those of the control group. Two weeks later, five of the alcoholics showed clear rebound thrombocytosis, an increased number of blood platelets. When a process was used to aggregate the platelets in blood plasma samples, the platelets of the alcoholics synthesized as much as triple the amount of thromboxane B_2 as the volunteers. This was the first time this finding had been made, the researchers said, and may contribute to the increased risk of thrombotic diseases in the alcoholic, although they said it is not clear whether the rebound thrombocytosis could also be responsible.

Acta Neurologica Scandinavica, Dec 1984, v.70:432-437

Pat Rich

Patrons tipple under watchful eyes of specially-trained bartenders

By Maureen Brosnahan

WINNIPEG — The Alcoholism Foundation of Manitoba (AFM), the Manitoba Hotel Association, and the Manitoba Liquor Control Commission have joined forces to set up a special program to help bartenders and hotels cope with customers who drink too much.

Dario Perfumo, executive director of the hotel association, said the idea for the course stemmed from a committee set up by the province's attorney-general to look into the problem of drinking and driving.

"It occurred to us that there's a social concern as to the harmful effects of drinking and driving," Mr Perfumo said. "We thought we should develop something as a starting point to make our members better aware."

But Mr Perfumo said the legal implications for association members who can be charged for serving liquor to an intoxicated person is also a concern.

In a January 1984 decision, the Ontario Supreme Court awarded a settlement of more than $1 million in a case involving two under-age drinkers. In that case, the Supreme Court jury laid 15% of the blame for the August 1980 car accident, which left the young passenger paralyzed, on the establishment which served the youths. The driver was found 55% responsible, and the passenger, himself, 30% responsible.

"It's not only the liability, it's the responsibility," Mr Perfumo told **The Journal**. "Licensees in the last few years have become extremely aware of their responsibility."

Ross Ramsey, executive director of the AFM, said the course will be conducted at various locations throughout the province to ensure that all hotel operators and employees have access to it.

Irene Hamilton of the liquor commission said her organization's role will be to provide information and answer questions about the rules and the law at these seminars.

"There's a growing concern which we share in drinking and driving," she said.

Mr Ramsey said all three parties have been working on the project for the past several months. Its primary purpose, he said, is to teach people how to recognize an intoxicated person and how to deal with that person diplomatically and tactfully.

Mr Ramsey said servers are often faced with the problem of how to tell when a person has had too much. "One of the things we are going to build into the course is how to detect the observable signs.

"There are ways of handling intoxicated people which are effective, and we think we can teach them," he added.

The cost of the program will be minimal, since it will be developed by all three groups using AFM staff.

The course, which will be offered to more than 1,000 people, will cover knowledge of liquor laws and teach techniques for recognizing intoxication levels and methods of cutting off customers who have had too much to drink.

Mr Perfumo said course content will also vary for establishments and clientele such as those in the rural and northern areas of Manitoba.

He said many of his members have volunteered space in their hotels for the seminars. They have also agreed to pay the salaries of their employees for the proposed four hours of course time.

He said the course has already met with enthusiasm from members and, if successful, will be ongoing to ensure new staff have access to it.

"We look at it as a very good investment," Mr Perfumo added.

Far more money is needed in addictions field: Califano

By Lynn Payer

NEW YORK, NY — The United States should have a National Institute of Addiction, says Joseph Califano, former US Secretary of Health, Education and Welfare. And, he said, putting more money into the field of alcoholism and drug abuse would have a "staggering impact.

"There is no more important problem in health and human tragedy in the United States than addiction, and the number one piece of that problem, overwhelmingly, is alcoholism," he said.

Mr Califano, now a New York attorney, told the gathering, sponsored by Grantmakers in Health, that a national institute was necessary because "until you have that kind of commitment . . . you can't get the best minds to work on it.

"We've got the best minds working on cancer, because they know the bucks are there," he said. "We're looking at a problem at least as intractable as cancer. To get really bright people to work at something where the odds are against making major breakthroughs, you've got to ensure them financing."

Currently, alcohol and addictions don't get their share of either public or private monies, he said. By one measure of funding, he said, "alcohol gets about 30 cents per patient, cancer gets $66, cystic fibrosis $131, and muscular dystrophy $175 per victim."

Although people are better informed than they used to be about alcoholism, "we don't have a sense of how pervasive it is, touching every part of our society," he said.

To illustrate his point, Mr Califano cited the following US statistics:

- There are at least 13 to 14 million alcoholics and problem drinkers in the US, among them three million teenagers. In a typical suburban community mental health centre, 17% of the older patients are either alcoholics or problem drinkers. Every man, woman, and child has a friend or relative who is a problem drinker.

Califano

- Drunk driving kills about 25,000 people a year, and alcohol is implicated in the deaths of from one-third to three-quarters of 8,000 pedestrians killed by automobiles.
- Cirrhosis kills 11,000 people a year.
- Hospital emergency rooms see more people because of alcohol abuse than any other reason, and one-third of general hospital admissions are related to the misuse of alcohol. Chronic brain injury caused by alcohol abuse is second only to Alzheimer's disease as a known cause of mental deterioration in adults. But not only do alcoholics consume a disproportionate share of the health care budget, so do their families. Five percent of all birth defects are due to alcohol abuse during pregnancy, and the use of health services by family members of alcoholics drops by as much as 60% six months after an alcoholic goes into treatment for alcoholism.

"The best estimate we have suggests that the annual health and medical cost of alcoholism and heavy drinking approaches $20 billion," said Mr Califano. "The overall cost to the country is estimated to be $120 billion in lost productivity and wages."

- Alcohol is involved in 76% of homicides, 50% of rapes, and 70% of child molestations. Routine screening of inmates in correctional facilities in New York State indicates that 40% have alcohol problems. Forty per cent of family court problems in New York City involve alcohol. Alcohol-related crime costs the nation an estimated $6 billion a year.

Because alcohol abuse affects society in so many ways, Mr Califano said, funding projects should not be left to organizations with a narrow focus on addiction or on health. He also pointed out that with a shift to health provision by profit-making organizations in the United States, some alcohol abusers — those with jobs, insurance, and a family —would be well-served while others would not be. He urged the grantmakers to see what they might do for those others.

While Mr Califano was pessimistic about the chances of public funding in a time of budget-cutting, he was optimistic about the field in general. "I think we're very close to learning more, we're very close to major breakthroughs."

"We may not know what causes alcoholism, but we're learning. We may not have enough treatment capacity, but we're doing a better job of treating the alcoholic now than ever before. We're getting better at identifying the disease earlier, and the earlier you identify it, the better the chance of treating it."

GILBERT

'Hosts would enquire about their guests' means of transportation, and keep a watchful eye on the alcohol intake of those who said they were going to drive.'

Blame the host

By Richard Gilbert

When people drink alcoholic beverages, they progressively lose the ability to judge how much they have drunk and how impaired they are. Drinkers usually feel they are capable of more than they can do. In particular, drinkers are inclined to believe they can drive safely when they have drunk enough to be impaired. Society would be wise to ensure that other people are responsible for the actions of such drinkers.

As far as drinking in public places is concerned, a person holding a licence to dispense alcohol already has considerable responsibility. Each Canadian province, for example, prohibits the sale of alcohol to people who are intoxicated or apparently intoxicated.

In common law jurisdictions (ie, all of Canada other than Quebec), tavern owners and other licensees have long been required to control the conduct of their patrons, but until 1973 their liability was limited to injuries that occurred on or in relation to the licensed premises. Then the Supreme Court of Canada ruled that a tavern owner has a common law duty to protect intoxicated people from injuries they might suffer on and off the premises (**Jordan House Ltd** vs **Menow and Honsberger**).

The case involved a regular hotel patron who drank too much one evening and was hit by a car while staggering home. The patron sued both the hotel owner and the driver. The court found in the patron's favor, but also found the patron one-third liable and reduced the damage award accordingly.

General duty of care

In reviewing this and another case, Robert Solomon and two colleagues at the University of Western Ontario concluded recently that ". . . the courts are moving towards imposing a general duty of care on tavern owners to protect their intoxicated patrons."

In Ontario and the Northwest Territories, there are laws that go further in that they create liability upon sellers of alcohol when an intoxicated person injures a third party. A well-publicized case in Ontario — **Schmidt** vs **Sharpe** et al (1983) — involved a passenger who became a quadriplegic as a result of an automobile accident that occurred shortly after he and the driver had left a hotel where the driver had been drinking. Damages of more than $1,390,000 were awarded against the driver and the hotel owner.

Such laws are more common in the United States where, according to Mr Solomon and his colleagues, 23 states ". . . have enacted a statutory cause against providers of alcohol." The highest award appears to have resulted from an action in California in 1984. Damages of $10.9 million were assessed against the owner of a liquor store who sold beer to a drunken teenage driver. The damages were awarded to the family of a man who was killed in a subsequent traffic accident.

Mr Solomon and colleagues concluded their recent article as follows: "Every time tavern owners or their staff serve a patron alcohol past the point of intoxication, they are exposing themselves to a possible suit. In order to avoid liability, Canadian taverns will have to introduce far more rigorous serving practices. This will cost money in terms of training, increased staffing costs, and reduced sales. Tavern owners who ignore the Schmidt case and its implications may maintain their profits, but only at the risk of financial ruin in a civil action."

Elsewhere in the article the authors wrote, "The clear trend in the law is towards the expansion of liability for all those who sell or supply alcohol to others."

One way in which expansion of liability could occur would be to make suppliers of alcohol also liable when they have served alcohol to drivers who are subsequently charged with being impaired while driving. Another way would be to extend the liability to all suppliers of alcohol, including private hosts. I have argued in these columns about once a year since they began in 1979 that both kinds of expansion would be desirable as means of reducing the amount of impaired driving.

The logic behind the first kind of expansion is the same as the logic behind making driving while impaired an offence rather than allowing prosecution only when an accident has occurred.

The purpose of the sections in the Criminal Code of Canada that prohibit driving while impaired is to permit prevention of accidents in two ways. First, they allow police to apprehend a person likely to cause an accident *before* an accident is caused. Second, they encourage an impaired person to avoid driving rather than engage in the more difficult task of driving carefully to avoid an accident.

Provisions inadequate

The penalties for getting in the driver's seat of your car when you have been drinking are severe, including heavy fines and suspension of driving privileges for first offenders and, in Ontario at least, automatic jail terms for second and subsequent offences. Nevertheless, hundreds of thousands of Canadians still decide to drive when they have drunk enough to be legally impaired. The present provisions of the Criminal Code are clearly inadequate.

Most of the discussion about change has focussed on further increasing the penalties for impaired driving. A better strategy may be that of sharing the legal responsibility, particularly in a way that would interrupt the sequence of drinking and then driving.

The kind of sharing of responsibility I am talking about would involve making it a criminal offence to provide a person with alcohol without also taking precautions to prevent the person from driving or determining that the person will not be driving.

Such a provision, if enforced, would mean that a tavern owner could also be charged when a customer is found to be driving while impaired. The result would be an acceleration of a trend that is under way. Bartenders are attending seminars on how to spot customers who might soon be impaired drivers. Soft drinks and food are playing a more prominent place in bars. Taxi-rides home are being offered to unsteady clients (See page 4).

Expansion justified

The second kind of expansion of liability that I have advocated — to private hosts as well as licensed providers of alcohol — is justified by the data on where impaired drivers have been drinking. In Ontario in 1979, a survey was conducted in which 2,167 drivers were stopped at random at various sites between 9 pm and 3 am. They were asked where they had come from — a public place, such as a tavern or restaurant, or a private place, such as a home.

The results were as follows:

	Origin	
	Public	Private
All drivers	567	1,600
Impaired drivers	96	80

Thus, even though a much greater proportion of drivers who had come from a public place had a blood-alcohol level in excess of 80 mg/100 ml (17% vs 5%), the overall number of impaired drivers originating in private places was almost as high as the number originating in public places because nearly three times as many drivers had been in a private place.

These data provide almost as much justification for making private hosts criminally responsible for the subsequent impaired driving of their guests as for making licensed providers of alcohol criminally responsible for their customers.

In New Jersey, a step has been taken toward making the private host liable. The state Supreme Court ruled in July 1984 that an accident victim may sue a homeowner who serves alcohol to a guest who subsequently drives while impaired and is involved in the accident. The matter was eventually settled out of court, with the private host making a payment to the victim.

A preliminary report indicates that retail sales of liquor during the holiday period in New Jersey were 50% less than the previous year. The Supreme Court decision has been cited as a major factor in the decline. I have not yet seen firm figures on arrests for impaired driving in New Jersey or for traffic accidents involving alcohol, but indications are that the numbers have fallen substantially since the decision.

Making private hosts liable in Ontario, even for accidents alone, rather than for all incidents of impaired driving, would change the character of social behavior in this province. Hosts would become much more inclined to adopt strategems such as providing a liberal supply of attractive non-alcoholic drinks, regulating the serving of alcohol through a bartender, removing alcohol long before guests depart, and many others.

Hosts would enquire about their guests' means of transportation, and keep a watchful eye on those who said they were going to drive. Hosts would arrange alternatives for drivers who drank too much. This is the behavior the legislation would be designed to encourage. It may be the surest route to reducing the amount of drinking and driving.

INTERNATIONAL

'Homebake' drug craze baffling NZ officials

Tony Garnier reports

Overdose deaths rising as addicts cook up drug from codeine painkillers

WELLINGTON, NZ — Young New Zealanders have pioneered a new drug abuse cult, and it has the authorities worried.

The drug is known as "homebake" and comprises an impure morphine and heroin-like substance made from codeine-based painkillers available at local pharmacies.

While police in recent years have been relatively successful in curbing the importing of heroin into New Zealand, they are now faced with a glut of homebake morphine manufactured in numerous private laboratories.

Since October 1984, at least one person a month has died in Auckland from an overdose of homemade morphine. This compared with just two fatal morphine overdoses in the whole of New Zealand in 1983.

Carrington Hospital medical superintendent, Fraser McDonald says homebake addicts are pouring into the hospital's drug clinic. "We got 40 new ones in the last fortnight."

Dr McDonald is also concerned about the impurity of the drug. Most batches of homebake comprise impure homemade morphine and heroin sold in liquid form. Different batches have different strengths which make the drug highly unpredictable, and easy to overdose. As well, some batches have "strange" chemicals which haven't yet been identified.

A department of science analyst, Sue Nolan, says the uncontrolled manufacture of homebake is producing a variety of by-product contaminants which have yet to be identified. Toxic chemicals used to make the homebake are also finding their way into the drug. One of them, pyridine, is known to cause sterility in men.

Authorities believe a million-dollar industry has been spawned in the name of homebake. The drug is selling on the Auckland drug market at about NZ$120 (Cdn $75) a shot. And science department analysts say sales of codeine-based painkillers have increased by about three million tablets a year in the past 24 months.

If even a tenth of this increase is being used for homebake, it represent tens of thousands of doses, worth millions of dollars. The government's science analysts say it takes only three large packets of codeine painkillers, available for a few dollars at a pharmacy, to make up to 50 shots worth at least NZ$100 each.

Both police and government scientists are convinced there is only one recipe, which has been distributed, at a price, throughout New Zealand and into Australia. Police say they know who developed that recipe: a person from a well-to-do background who attended a prestigious boarding school and studied chemistry at university. There, police say, he discovered how to make a variety of drugs and perfected the homebake recipe, which has since been widely circulated.

But not everyone has been able to use the recipe successfully. Dr McDonald reports cases of young Aucklanders putting themselves into comas through efforts to make homebake.

He believes that until the process spread recently to Australia, homebaking was known only in New Zealand. Ironically, the growth of homebake was largely a result of the efficiency of New Zealand police and customs officials in keeping Asian heroin out.

Police say homebake is now widely available in most New Zealand cities. Homebake "cooks" operate on a small scale, and nearly all are addicts. Their clients will often visit pharmacies across a city, buying only a few packets of painkillers from each to avoid suspicion. These are used as part payment for homebake.

Most homebake sold on the street is impure morphine. A young addict recently startled radio listeners with a graphic description of the effect of homebake, and the risks she took not knowing whether the "shot" was pure or spiked.

Another problem centres on treatment. Dr McDonald says addicts at the Auckland drug centre are not responding well to treatment. And he predicts the problem will get much worse unless restrictions are placed on codeine-based painkillers.

He suggests the major cause of homebake narcotic addiction is availability.

Codeine restrictions will cut down the supply, and so the addiction, he argues. Pharmaceutical authorities are taking voluntary action to restrict sales of large packets of codeine-based painkillers. It will mean customers signing for the drugs and providing identification.

However, pharmaceutical representative John Ferguson said he believes homebake is a passing fashion. "If it's not this it will be something else." He argues that putting codeine painkillers on prescription, as in the United States, will lead to more break-ins and hold-ups.

Health Minister Dr Michael Bassett has called for a report. Meanwhile, his officials say restrictions may help, but, they argue, because codeine-based drugs are available in so many different products, restrictions are not the full answer.

"We mustn't kid ourselves that by doing this (imposing restrictions) the problem will go away — people will make more effort to get it," says a health department adviser, Dr Ralph Riseley.

However, Dr McDonald argues that if codeine was restricted and if people try to obtain it illegally, at least they could be caught and treated.

Western funding aims to halt flow of Pakistan heroin

By Thomas Land

VIENNA — Western governments have launched a coordinated investment program intended to counter the spread of drug abuse at home by encouraging opium growers in the Middle East to switch to alternate crops.

The illicit trade has now reached such vast proportions that the United Nations intends to declare drug trafficking a crime against humanity.

The Western investment plan focuses on the tribal lands of the North-West Frontier Province of Pakistan because the region has emerged as the biggest single source of heroin trafficking world wide (**The Journal**, July 1983).

Britain has just made a $1.3 million contribution to the UN Fund for Drug Abuse Control (UNFDAC) to support agricultural investment in Pakistan. It followed the United States and Italy which committed $5 million each and West Germany which put up more than $3 million. Further investment may well be forthcoming from Canada, Nordic Europe, and elsewhere.

Guiseppe di Gennaro, the executive-director of the Vienna-based UNFDAC, says the international drive, which is so far limited to the Buner area of the North-West Frontier, is "the first crop substitution project in the world to have achieved its goal of completely eliminating (opium) poppy cultivation without causing undue hardship to the local inhabitants."

The Pakistan government estimates that about 44 tons of illicit opium were produced in the 1983-84 growing season, down from 800 tons in 1978-79.

Under the UN Special Development and Enforcement Plan now financed by the West, several new agricultural development projects are to be established in the province to offer opium growers an attractive, alternative livelihood. The five-year plan will cost about $30 million for agricultural extension, liveslock, irrigation, roadbuilding, and drinking water supply.

Market scene: tribal laws shielding heroin labs?

Peshawar, Pakistan: in the heartland of the Golden Crescent

The North-West Frontier province is the productive heartland of the notorious Golden Crescent of the Middle East, a vast opium growing area comprising Pakistan, Afghanistan, and Iran.

The world's other principal source of heroin is the Golden Triangle of Asia which includes bits of Thailand, Burma, and Laos. Its productivity has recently declined because of a variety of factors, including several internationally-supported crop substitution projects and a Western-inspired military clampdown by the Thai government.

A coincidence of circumstances has enabled the opium growers of the North West Frontier to dominate the lucrative Western markets for heroin. The prolonged war in Afghanistan and the revolutionary turmoil still shaking Iran have led to the establishment, for the first time, of an extensive cottage industry in the province for the conversion of local opium into heroin. Shielded by the tribal laws of the region, the heroin laboratories operate in relative safety. And their emergence has set off a productivity explosion, flooding the black markets of the world with inexpensive, high-quality heroin.

The change is reflected in the phenomenal growth of heroin shipments seized by Pakistan — 1,800 kilograms in 1983, up from 10 kg in 1980.

Heroin addiction in Pakistan, which was virtually unknown at the turn of the decade, is now widespread and growing — measured in terms of several tens of thousands of young abusers. The Pakistan government recently introduced tough new laws to discourage drug trafficking, and it is now considering the imposition of the death penalty.

The governments of the West are equally worried. The flood of Pakistan heroin reaching their countries has found a ready and expanding market in a generation of vulnerable school leavers seeking diversion from bleak employment prospects.

UN Secretary-General Javier Perez de Cuellar says that he is "impressed by the number of world leaders who have come to pay priority attention to the devastating effects of drug abuse both in the developing countries and in the industrialized world."

A draft convention recently placed before the UN Commission on Narcotic Drugs is to declare the illegal trade as "a crime against humanity" in which the involvement of public officials would be considered as a gravely aggravating circumstance.

The UN General Assembly has also passed a resolution demanding "the most urgent attention and maximum priority" to be paid by governments to cooperative measures, such as the North-West Frontier program, for the control of drug trafficking and abuse.

CPhA program gaining nation-wide support

Manitoba pharmacist's tobacco ban paying off

By Maureen Brosnahan

WINNIPEG — Harvey Cantin hasn't sold a cigarette in his Winnipeg pharmacy in almost eight months, and he says it has been profitable in more ways than one.

Mr Cantin, who has operated his west Winnipeg pharmacy for the past 23 years, dropped cigarettes from his product line last summer as part of a national campaign launched by the Canadian Pharmaceutical Association (CPhA).

So far, he has had no regrets.

Although he sold between $15,000 and $20,000 worth of cigarettes a month, Mr Cantin said there was little profit in it since his prices were barely above cost.

In fact, he said, dropping cigarettes and tobacco has meant fewer headaches for his staff who often spent hours keeping track of inventory and setting up displays. Now, he said their time is used much more efficiently.

As well, with people no longer buying cigarettes from him in cartons, he has fewer people using credit cards, which cost him a service charge.

Mr Cantin told **The Journal** there are benefits to the change. "It's not one big thing. It's sort of an accumulation of things," he said.

Last summer the CPhA introduced a national campaign to encourage the country's 5,446 pharmacies to urge people not to smoke by providing educational material, refusing to advertise tobacco products, or refusing to sell them (**The Journal**, April, 1984).

Of Manitoba's 249 retail pharmacies, 15 do not sell tobacco, 27 refuse to advertise it, and 71 provide customers with educational information, said Leroy Fevang, executive director of the association in Ottawa.

Mr Fevang said he's pleased with the response rate in Manitoba and across Canada. He said about 40% of all pharmacies are participating at some level in the program.

Mr Fevang said the campaign will continue for at least two more years.

Mr Cantin said it took him about a month to deplete his stock last summer, and he said he received good cooperation from cigarette manufacturers. "Everything has gone very nicely, very smoothly."

He said his customers have been very supportive. "There was not one negative reaction . . . . I didn't realize how many people were supportive of this."

Cantin: no regrets on dropping cigarette sales Winnipeg Free Press

Mr Cantin said he's not a non-smoking fanatic. After all, he does smoke a pipe. "I'm not a crusader. But I just thought this was right. We should get out of selling cigarettes," he said.

Jack Davis, executive director of the Manitoba Society of Professional Pharmacists, said he expects more will follow Mr Cantin's lead.

"Strictly speaking of the financial aspect, you're not making any money anyway," Mr Davis said.

But he said many pharmacies use tobacco as a drawing card for customers, and some studies estimate that 25% of all tobacco products in Canada is sold through drug stores.

"I guess probably the attitude of a lot of pharmacies is that it (tobacco) is a traditional product," Mr Davis said.

Stewart Wilcox, registrar of the Manitoba Pharmaceutical Association, said the problem is that traditions die hard and can't be changed overnight. "I think it will slowly change," he said, especially since two-thirds of Canadians are now non-smokers.

"I think when people (pharmacists) see they aren't going to go out of business, it will change," Mr Wilcox said.

Penalties should be swift not stiff to deter drinking drivers: insurers

By Betsy Chambers

HALIFAX — The Insurance Bureau of Canada (IBC) is concerned the heavy emphasis on bigger fines and longer jail terms is not producing a dramatic reduction in drunk drivers.

In unveiling the IBC's six-point policy on drinking and driving here, Jean Robitaille, the IBC chairman, said the get-tough measures were not reaching the heart of the issue — changing society's relative acceptance of the drinking and driving phenomenon.

"The evidence seems to show that it's not a workable deterrent. It hasn't improved the situation," he said, referring to governments' attempts to get drunk drivers off the road through legal sanctions.

The federal government has stated its intention to tighten the Criminal Code with respect to drunk drivers (**The Journal**, Jan), and, in Nova Scotia, amendments

Giffin

Burke

were made in 1984 to suspend for a year the drivers' licences of first offenders. Second, or more frequent offenders are now required to undergo assessment by the Nova Scotia Commission on Drug Dependency before regaining their licences. And the province has provided every municipal police force with roadside breath testing equipment and training in how to use it.

Marvin Burke, executive director of the Nova Scotia Commission on Drug Dependency, told **The Journal**: "You have to do something about the people who are still going to drink and drive" in spite of governments' attempts to disuade them.

Nova Scotia Attorney General Ron Giffin agrees tough enforcement has to be a priority, but the law now "really takes it as far as it can usefully go."

Canadian insurers pay out roughly $1 billion to $1.5 billion a year in claims related to drunk driving. Annually, about 2,000 people are killed in Canada in motor vehicle accidents in which alcohol consumption has played a role.

Mr Robitaille argued that admitting more people to the country's already over-crowded jails, and charging bigger fines that discriminate against the poor, would not curb the problem. "We don't think it's the best way of dealing with the situation."

In a speech here to the Rotary Club, Mr Robitaille said, "all the available evidence suggests swift punishmcnt is a more effective deterrent than stiff punishment."

The IBC wants a concerted advertising and education campaign to make drinking and driving socially unacceptable, year-round road-side checks for drunk drivers, a raise in the legal drinking to 21, the issuance of two-year probationary licences for all new drivers, an increase in administrative 24-hour licence suspensions, and the use of photographs on all drivers' licences.

Mr Burke regards some of the IBC proposals as constituting more enforcement. He doesn't oppose any of the ideas in principle, provided they are part of a broader, wholistic approach.

Many of the ideas put forward by the IBC are already either under examination or adopted in modified form in Nova Scotia, Mr Giffin told **The Journal**.

The Premier's Task Force Against Drunk Drivers, for instance, is considering raising the legal drinking age to 21.

Mr Burke: "Sure it's fair to take a look at it, but if it's taken as being the answer, then I say look out. If you look at it as one piece of the whole, then that is a different matter."

He supports an information campaign of the type the IBC calls for, "but awareness is only one part of the whole. When you can guarantee the likelihood of being caught, it can increase awareness. That's important too."

Mr Robitaille agrees, but says the court system is often too slow to be effective as a deterrent. For that reason the IBC is calling for more roadside checks and the use of 24-hour licence suspensions.

In Ontario, police are handing out 12-hour suspensions for drivers caught with a 0.05% blood alcohol level. More of this activity, with longer suspensions, is what the IBC has in mind.

But Mr Giffin said he anticipates a court challenge to the Ontario policy based on the Charter of Rights and Freedoms. And he said he would be loath to consider implementing such a measure in Nova Scotia until its legality was cleared-up in the courts.

Police now are checking more often in Nova Scotia for drunk drivers, and the province also has a probationary licence system in place.

The IBC wants photographs of drivers on their licences because, in Ontario alone, it is estimated that between 40,000 and 60,000 people are getting behind the wheel without a licencc.

The insurance industry is concerned because thcse peoplc are uninsured, and they can become involved in accidents that cause scrious injury to others.

Mr Giffin said he is not certain how serious the problem is in Nova Scotia, but said putting photographs on licences to reduce the problem would be costly and administratively cumbersome.

Cocaine, heroin overdose deaths hit record high in Capitol area

WASHINGTON — Overdose deaths from cocaine and heroin doubled in 1984 in the District of Columbia and were the highest ever recorded.

District of Columbia police said 138 cases of heroin overdose deaths were reported, twice that for 1983. A massive increase of supplies of cheaper and more potent heroin was the major cause.

At the same time, 88 people died of cocaine overdoses. The drug was used mainly in combination with other drugs. In 1983, there were 45 cocaine overdose deaths. Overdose deaths in which PCP (phencylidine) was found to be in the bodies remained static: 69 in 1984 compared with 65 in 1983.

Police officials were pragmatic about the future: more heroin and cocaine is flowing into the country, purity is higher, price is lower, and overdose deaths are expected to increase.

Young driver training kit warns of drinking dangers

By Terri Etherington

TORONTO — Driver education classes may be the best time to reach young people with messages about drinking and driving, says Alcohol and Drug Concerns, Inc (ADC) here.

That's why they've targetted 14 to 16 year olds in an information package designed to tell young people about the dangers of combining alcohol and automobiles — before they get behind the wheel.

"This is hitting them just at the point when they are getting thirsty for driving information," says Karl Burden, executive director of the ADC, a voluntary, non-profit organization.

The kit, *Ready for the Road?*, which includes a comic book, quizzes, a bumper sticker, and an information booklet, will be distributed to 100,000 young people enrolled in Ontario high school driver education classes. The kit will also be made available to young people taking private driver education.

Mr Burden told **The Journal** the ADC recognized a need for a program for young people which would do more than just say 'thou shalt not drink and drive.'

"This is not a scare tactic," he commented. The materials are written for young people and are intended to show recognition of the decisions and problems facing young people with respect to drinking and driving.

The comic book, *A Friend for Life*, outlines young peoples' concerns, parental reaction, and suggests alternate ways of handling the peer pressure to drink and drive.

Mr Burden said the comic book is a "catcher," adding that it probably is the resource young people will turn to first when opening the package.

"It is an attempt to say to young people, 'hey, we understand a bit about the problem,' " Mr Burden said.

The pamphlet, *Who Says?*, deals with some of the myths about alcohol and automobiles, and points out some of the hazards.

The message is succinct: "Don't drive with drinks or drunks."

A more detailed booklet, *What's it to Me?*, outlines the statistics, the laws, and legal penalties, as well as some social and emotional penalties — things Mr Burden says young people often don't consider.

When young peoples' attention is focused on the prospect of beginning to drive, these considerations might hit home with more impact. "If your father is going to have to pay $2,000 for insurance, you are not likely to be driving the car," Mr Burden said.

Ready for the Road? was prepared and designed by the ADC with sponsorship from the Insurance Bureau of Canada and Suncoco. Distribution of the kit to driver education classes will be carried out by the Ontario Safety League.

Comic: other ways of handling peer pressure

EDITOR
Anne MacLennan

PRODUCTION EDITOR
Terri Etherington

CONTRIBUTING EDITORS
Karin Maltby (Toronto)
Harvey McConnell (Washington)

CONSULTANTS
Dr Oriana Josseau Kalant
(Science)
Robert Solomon
(Law)

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053 Advertising 595-6113 Subscriptions 595-6056

CORRESPONDENTS
John Carroll (New Brunswick)
Maureen Brosnahan (Winnipeg)
John Dornberg (Munich)
Manfred Jager (Winnipeg)
Tom Land (London)
Betty Lou Lee (Hamilton)
Allan Massam (London)
Lachlan MacQuarrie (Hong Kong)
Jean McCann (Cleveland)
Pat McCarthy (New Zealand)
David Milne (Toledo)
Tim Padmore (Vancouver)
Lynn Payer (New York)

Member of ebp

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Role underestimated

Library aids computer search

As access to computers becomes an everyday reality, many researchers like Richard Gilbert will undoubtedly attempt to perform their own on-line bibliographic searches.

But in his article on microcomputers (**The Journal**, Feb), Dr Gilbert has underestimated the value of the role of librarians.

Librarians augment the usefulness of computers. Their knowledge of searching techniques using multiple databases, computer command languages, and the different vocabulary structures offers users the high recall and precision needed to maximize the use of bibliographic databases at a minimum of cost.

Unfortunately, some users shortchange themselves in an effort to expedite the research process. To make full use of a library's service, a user needs to take the time to work with the librarian during the search. This is especially useful when the client is an expert on the subject and can assist in the course of the search. Thus, the problem of a "wild goose chase" can be circumvented.

In on-line bibliographic searches, the librarian acts as an intermediary between the end user and the databases. The librarian translates the user's enquiry into the language of the selected system(s) and provides the user with the desired documents.

Effective use of the online bibliographic systems requires training and continuing education. An experienced librarian can also provide the expertise acquired through extensive searching using multiple databases.

For those who are contemplating doing their own bibliographic searching, the following should be considered:

- Are you prepared to go to training seminars to learn how to use the system?
- Do you have the time and financial resources continually to upgrade your skills and knowledge of searching techniques?
- Will you use the facility often enough to gain the expertise?
- Will you use it often enough to make it cost-effective?

Inexperienced searchers can create quite different results.

Margy Chan
Manager, Library Services
Addiction Research Foundation
Toronto, Ont

Amethyst centre program is growing, changing

It was disturbing to open **The Journal** (Dec, 1984) and find an article about Amethyst which, because of the source of the information, makes it inaccurate when speaking in the present tense.

I am aware that Dr Virginia Carver sent you our research report which was prepared for Health and Welfare. That report is now almost one year old and, as well, the data and statistics used in it are based on a different program format and, of course, different numbers than are true at present.

We are not funded by Health and Welfare at all, though we once were. Nor do we offer a course in assertiveness training as your article implies — but rather an introduction to assertiveness. Within the group process we do encourage women to be assertive. This, along with all the other issues which affect our clients, both as women and as chemically dependent people, are woven into a treatment program designed to deal with alcohol and drug addiction. This is where the emphasis must lie since our purpose is to help addicted women to recover.

We are delighted to share our successes, particularly if they can be helpful to others, but as with all things, Amethyst does not stand still. The research report is history as are past statistics. Amethyst has grown and changed dramatically these past few years, which the figures quoted in your article do not reflect.

Tanya Owen
Executive Director
Amethyst
Womens Addiction Centre
Ottawa, Ont

Many readers for each issue

I enjoy reading **The Journal** tremendously and circulate it among so many interested people. My husband reads it, after which our sons and their wives in turn have it. I then bring it to work to circulate among a large group of nurses at Centenary Hospital where I work as an RN. If we still can find it, it remains in the patient's lounge.

I quite often hear discussion from various topics of **The Journal** in our "nurses lounge" at work.

Many thanks and keep up the good work.

J. Dugas-Rosentals
Scarborough, Ont

TJ saves reader research time

The Journal keeps me up-to-date on what's happening all over, not just locally, without having to spend a great deal of time on research myself.

Having seen so many alcoholics in the terminal condition of their disease, I'm interested in research in liver diseases and brain damage.

I wonder why no comparison has ever been done about our willingness to destroy opium growers in The Third World but our allowing our own tobacco farmers to receive government subsidies.

A. Wiles
London, Ontario

Montreal hosts AA conference

I have read **The Journal** for years and have always regarded it as one of the best in the world.

I recently received the January issue and noticed that the International Alcoholics Anonymous (AA) Convention in Montreal this summer was not mentioned on the International Youth Year calendar or on the Coming Events page. It sometimes scares me how little credit we give AA in the field of substance abuse.

I know **The Journal** didn't just overlook this event, and there must be some reason for this important event not being published.

Don Berg CSAC
Executive Director
Louisiana Alcohol and Drug Abuse Consultants
Baton Rouge, Louisiana

Editor's note: The International AA Convention has now been added to our list of Coming Events. However, prior to our contacting them on receipt of your letter, the AA offices had not alerted ***The Journal*** *to this event.*

FEATURE

Soaring drug abuse choking world-wide health effort: WHO

Alcohol, other drugs, and cigarettes may soon rival schistosomiasis, small pox, and typhoid as endemic health problems in underdeveloped countries. In the past three decades, the World Health Organization (WHO) has been a major force in helping many poor countries to fight endemic diseases and to institute the rudiments of a health-care delivery system. Now, abuse of alcohol and other drugs, and the residual effects of cigarette smoking, pose problems fragile health-care delivery systems cannot cope with, and illegal trafficking that customs and police are incapable of controlling. In the first of a series of reports from WHO headquarters in Geneva, contributing editor HARVEY MCCONNELL discusses some of the problems with senior medical officers and drug experts Inayat Khan, MD, PhD, and Awni Arif, MD.

McConnell

A WHO study has estimated that there are some 48 million illicit drug users in the world: approximately 30 million cannabis users, 1.6 million coca leaf chewers, 1.7 million opium-dependent, and 700,000 heroin-dependent people, among others. At the same time, there is a lack of statistics on people abusing cocaine, psychotropics, and inhalants.

While particular cultures have favored particular drugs in the past, modern drug trafficking organizations and a worldwide transportation network have made it easy for drugs to shift around the world. This is one reason why cocaine is now turning up in the Far East, an area normally associated with opium and heroin use.

Two groups in particular are affected by cannabis: adult smokers in rural areas of Africa and the Middle East, and the young in urban and semi-urban areas of North and Latin America, Europe, and the Pacific area.

While raw opium is limited to the Middle East and Southeast Asia, heroin use is spreading rapidly in Western Europe, although it seems to have stabilized in North America.

Hallucinogenic drugs, including LSD, peyote, psilocybin, and phencyclidine (PCP) are seen in young, urban populations in North America and, to a lesser extent, in Western Europe and Australia. Amphetamines, barbiturates, sedative hypnotics, and tranquillizers are being increasingly abused in many countries, and solvent sniffing is spreading among many pre-adolescent and early-adolescent populations. And, now, cocaine.

While the Andean Indians continue to chew the coca leaf, as they have for centuries, in many of the same areas more and more young people are smoking coca paste (**The Journal**, May 1984).

Dr Arif, senior medical officer in charge of the Drug Dependence Program, WHO division of mental health, thinks the future is not rosy; drugs are now being consumed by all age groups and by both sexes, with the major prevalence in urban populations among those up to age 30.

In reviewing all the evidence, he concludes that "in many developing countries, communicable diseases will be under control in the next 10 years, which leaves drugs and alcohol and cancer, unless we find a breakthrough, and some cardiovascular diseases, as the major social health problems we will face in the next 20 years."

In many countries where opium was used traditionally — and successfully — as an aid in many medical conditions, heroin is now a problem.

A four-year assessment of cocaine, from adverse consequences to prevention approaches, has been drawn up by the agency based on assessment from investigators around the world and from agencies, such as the Addiction Research Foundation in Ontario, and the US National Institute on Drug Abuse, which are collaborative centres with the WHO.

Arif: cocaine hard to predict

Dr Khan, senior medical officer in the WHO division of mental health, recalls his youth in Pakistan where in his village there were a few men who ate or smoked raw opium but this was not a problem. "Now the demand for heroin smuggled in from the remote tribal areas of Pakistan is affecting hundreds of thousands of people. Heroin is now one of the great challenges to the nation."

Dr Khan, who is impressed by the rapid rise of the parents' movement in the United States in recent years, says many members of his family are involved in the Green December Movement. This is a volunteer movement started in December 1983, "by people who see a great danger and want to fight heroin addiction. Its membership includes all strata of society: from the taxi driver to the man from the mosque; from the policeman to the teacher and the psychiatrist."

Dr Arif says that illegal drug abuse does not lend itself to epidemiological reporting, such as has been the case with cholera, smallpox, typhoid, or other diseases where there is a regular reporting system.

Because of legal sanctions against so many drugs, he adds, "the most difficult thing is to make an assessment of the extent of the problems."

He notes that not everyone who uses illicit drugs becomes dependent; some can use them for long periods and then quit. "It is like a micro-organism: not everyone exposed contracts the disease."

The one drug he sees as different is cocaine. "Because it has such a strong reinforcing property, it is hard to predict what will happen," Dr Arif says.

"It all depends on the political decisions, international action, and concerted effort on supply; I would say that supply control will play a more important role in prevention in the area of cocaine than any other drug because of the limited area of the world where it is now produced," Dr Arif contends.

He notes that at the moment the coca bush is confined to one geographic area in South America, unlike the opium poppy, which is cultivated from Australia to Mexico.

He also notes that about eight years ago, when the authorities in West European countries were warned about heroin, the reply was that heroin was a US problem, not a European problem.

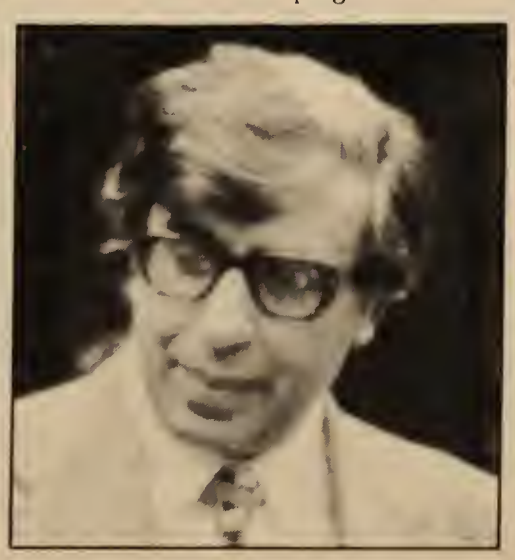
"It is now a European problem. Heroin is now a big public health problem in countries such as France, Holland, some Scandinavian countries, Italy, and the Federal Republic of Germany," he adds.

Dr Khan, who is both a doctor and a pharmacologist, specializes in surveying the use of psychotropic substances around the world. One of his major concerns has been the rise of amphetamine abuse in the last five years in Africa and the Middle East.

He has been in Nigeria during harvest time and seen the tablets being flown in by the millions to be sold cheaply to farm laborers. In all the affected countries, both government officials and the health professionals are worried because amphetamines are inexpensive and so many people are becoming intoxicated.

What is urgently needed is a monitoring system to see what is happening in a particular country in the use and abuse of psychotropic substances and what becomes of the users. "We need a concerted effort so that the developing countries can monitor the problems," Dr Khan says.

Dr Khan believes that while it is not possible in the industrialized countries now to try to limit the number of psychotropic drugs available for prescription, it is something which is certainly feasible in underdeveloped countries. Periodic reviews could be carried out to see if there is a need to add any more to the available prescription list.



Khan: drugs replace endemic diseases

He wants to see the medical profession use psychoactive drugs in a more careful way. "They should not only prescribe for the patient: they should try to keep an eye on them, although there are times when one cannot help them."

Surveying the area of drug abuse, Dr Khan points out that "while we are learning to control endemic diseases, now drug abuse could become the major disease of the Third World."

Most Third World countries are completely unequipped to deal with such problems. Resources are scarce. It would be asking too much for a psychiatrist, who is overburdened at best in dealing with mental health problems, to get involved with drug abuse problems as well.

Dr Khan finds it is disappointing at meetings of the World Health Assembly to hear ministers from some countries deny they have a drug problem in the face of evidence to the contrary.

"In contrast, there are nations, like Malaysia, for example, who are frightened about drug abuse and have instituted legislation and programs. You land at Kuala Lumpur, and you see signs that say 'we will hang you if you deal with heroin.' This shows the response of the government."

Dr Kahn says that it is not enough for a country to claim it has no problems with drug abuse: it must present data to show it has no problem. "To say 'I have no problem' is just not an answer."

Investigation must include not only illegal drug use but also use and abuse of prescribed drugs, and even highway deaths: "you must look into the number of people dying on your roads and look for alcohol and other drugs in their body fluids."

Dr Khan says that one drug abuse problem which worries officials at the Eastern Mediterranean regional office of the WHO is the centuries-old custom by some of chewing leaves of the Khat plant. "Fortunately, the action of the plant is very limited, and it is only a matter of hours after it is picked. The leaves have to be chewed fresh, and thus it is self-limiting, really."

Like Dr Arif, he believes illegal drug use is mainly a law enforcement problem now, with major efforts being made in trying to control the supply. As for trying to dampen demand, efforts need to be made to retain the cohesiveness of the family as well as recognize the part religion plays in many societies, he said.

A recent progress report on abuse of narcotic and psychotrophic substances says the WHO is exploring the possibility of a common approach to alcohol- and drug-related problems. As an example, abuse of alcohol and such drugs as barbiturates and amphetamines is becoming increasingly common in both the developed and the underdeveloped world.

The report noted that international evidence of common patterns in the use of alcohol and other drugs continues to grow stronger, and there is a correlation between drug dependence and alcohol-related health problems. Multiple drug use is an increasing problem in countries all over the world.

The strategy of the WHO is cooperation with the countries in the development of programs and the maintenance of close collaboration with the United Nations agencies concerned with drug dependence, particularly such bodies as the International Narcotics Control Board, the United Nations Fund for Drug Abuse Control, and the UN Commission on Narcotic Drugs.

Another vital link is with WHO collaboration centres, particularly in training and research.

NEWS

Addicts' selfish behavior confronted in rehabilitation

By Betty Lou Lee

HAMILTON — There's a similarity of thinking between criminals and those who abuse alcohol and other drugs, a corrections psychologist believes. They both lack respect for authority, consideration for others, and responsiblity.

Prem Gupta is using this premise in a treatment program called Tough Talk, at the Guelph Correctional Centre, Guelph, Ontario, where he is chief psychologist. He is also the Western Ontario region coordinating psychologist with the provincial ministry of correctional services.

"There are no reasons why a person is an abuser or a criminal. This is the kind of person he is, the way he thinks," says Dr Gupta, dismissing factors like personal problems, abuse as a child, low self-esteem, fears, and escapism as not causes, but excuses and rationalizations.

"Give me one unemployed abuser, and I'll give you 10 unemployed non-abusers. Give me one depressed abuser, and I'll give you 15 depressed non-abusers.

"In our current state of knowledge there is no evidence any condition, or any combination, definitely leads to abuse."

Nor, he said, is there a factually established relationship showing that crime is committed because of alcohol and other drugs. "Even if he gives up alcohol and drugs, you just have a sober criminal on your hands."

The two often exist together, but so do being tattooed and committing crimes, Dr Gupta said.

These people think differently about the world around them, Dr Gupta said. "It's as if he is the centre of the universe, and nothing else matters; as if his eyes are turned inside, so he is oblivious, blind to others.

"All his energy and conniving are directed at, 'How can I get what I want?' He will do whatever it takes to achieve it."

In his program at the correctional centre, Dr Gupta uses four questions to bring about a change from hurting to helping others, insisting on honest answers, and resisting attempts to manipulate, con, and rationalize.

At first the inmates respond defensively to the first question, "How long have you been doing this (abusing or breaking the law)?" admitting only what can be proven by their record.

The second question, "How many people have you hurt in all those years?" also brings denial.

"You have to help him to see who he has hurt, because he doesn't even know his mother, wife, or children are hurting. He has no clue. He'll deny responsibility, deny injury, deny victims. He has no awareness he has done anything to anyone. He says things like, 'The insurance will pay.'

"He's observing a higher law that hasn't been passed yet."

It takes several months to convince an abuser he's hurt others, and even longer for a criminal to accept he's hurt his victims.

The third question is, "What did these people do to deserve being hurt?

"He still has enough sense of justice to know that they didn't deserve it. He's very emotional about others being fair to him."

Dr Gupta says it has been suggested that a person so confronted may become depressed enough to commit suicide, but it doesn't happen. "A person who thinks 'I am the universe' can't afford to die — he has too much to lose."

When the answer to the final question, "Do you want to continue what you're doing?" is no, he's helped to look for opportunities to help, rather than hurt others with whom he comes in contact, even in a small way.

"He's good at hurting others, an expert, but lousy at helping others. He has no clue, because he doesn't even see them. If he wants to be a loving, caring person, he has to practise it. If he gets good at this, then he can't do the opposite."

Inmates at his centre must wait up to six weeks before they are allowed to join the program. "Because we've been turning more away, more are coming . . . . We have found help should never chase any addict . . . he should chase you. If he feels you need to help, he won't."

While the approach appears a tough one, Dr Gupta commented, "you have to temper it with compassion, a lot of softness, and gentleness in the interviews."

Dr Gupta hasn't yet analyzed follow-up data, but changes in the first 18 men in the program have been "very noticeable," both to those in the centre, and those in the community after the prisoner has left, he said.

He outlined the Tough Talk program, it's theories, and some early data analysis at the recent meeting of the Ontario Psychological Association in Ottawa and also last year at the 25th Annual Institute on Addiction Studies held here.

A survey of parole officers of 70 former inmates who had participated in the Tough Talk program and 70 control subjects who had not participated, showed only slight differences. Dr Gupta told **The Journal**: "Initially there seems to be a very small difference. We hope that with further evaluation at six months to one year following release, differences will start to show up."

Although the program has been in operation for about three years, very little formal evaluation has been done. "Gut feelings," said Dr Gupta, indicate that inmates who have participated in the program are showing improvement in their abilities to relate to others and to consider others in their actions.

New position for David Smith


Smith

OAKLAND, Cal — David Smith, MD, has been appointed research director and alternate medical director of the Merrit Peralta Institute (MPI) Chemical Dependency Treatment Program here.

Dr Smith, a member of The Journal's Editorial Advisory Board, is founder, and will continue as volunteer medical director, of the Haight-Ashbury Free Medical Clinic in San Francisco.

At MPI, Dr Smith will supervise naltrexone research and services, consult with patients and physicians, and coordinate physician training programs at the 40-bed residential facilty. Dr Smith's duties will also include hosting national conferences at the Merrit Peralta Health Education Centre on such topics as the impaired health professional, pain management, and drug dependence.

Dr Smith is also associate clinical professor of toxicology at the University of California Medical Centre, San Francisco.

Schizophrenia-like illness sparked by alcohol abuse?

By Dorothy Trainer

BANFF — Alcohol causes a type of schizophrenia-like illness, a psychiatrist here believes.

Speaking at the Canadian Psychiatric Association's annual meeting here, Peter Hays, professor and vice-chairman, department of psychiatry, University of Alberta, said that where alcoholism rates are high, as in Ireland, the incidence of paranoid schizophrenia among males is also high.

However, he added, the American Psychiatric Association's diagnostic manual (DSM-III) has moved away from the alcohol-causation theory and suggests only a tenuous connection. In it, alcoholic hallucinosis is regarded as a rare syndrome associated with alcohol withdrawal, rather than use.

To test whether schizophrenic patients with a history of alcoholism are different from those without such a history, Dr Hays and a co-investigator selected 20 patients with DSM-III-diagnosed schizophrenia and antecedent alcoholism and a control group of such schizophrenics with no antecedent alcoholism.

"When the alcoholic patients were compared with the non-alcoholics on an 18-item questionnaire, it was clear that the alcoholics showed a much greater familial tendency to alcoholism. Alcoholics had commonly done things of which they were ashamed. Their illness was frequently hallucinatory from the start. Visual hallucinations were seen much more frequently than in the general run of schizophrenics. An elevated mood was comparatively uncommon, as was thought disorder."

Dr Hays concluded that these findings support the proposition that alcohol abuse, rather than alcohol withdrawal, causes one of the schizophrenia-like illnesses, with a syndrome marked by a hallucinatory onset and, at its height, by visual hallucinations and delusions.

Youth, Third World issues highlight Congress

CALGARY — A state-of-the-art policy document on smoking and health, and special sessions on youth and on emerging problems in the developing world will highlight the centenary International Congress on Alcoholism and Drug Dependence to be held here August 4-10.

The 34th Congress is designed to offer an international exchange of information on a broad range of addiction problems and treatment. The first was held in Antwerp, Belgium in 1885.

H. David Archibald, president of the International Council on Alcohol and Addictions (ICAA), the sponsoring body, said the conference is part of a series of activities of the ICAA. "One of the goals of the ICAA is information transfer — to provide opportunities for people from many different disciplines and many parts of the world to come together, to learn, and share experiences."

Smoking and health will be one of the major focuses of the Congress. Mr Archibald said a workshop on the impact of smoking on health, with special reference to developing countries, will be held prior to the Congress.

"And I hope from that workshop will come a policy document on what governments can begin to do to prevent the massive health damage caused by smoking, especially cigarettes," said Mr Archibald, founder of the Addiction Research Foundation of Ontario and now Commissioner, Royal Commission into the Use and Misuse of Illicit Drugs and Alcohol, Bermuda.

He told **The Journal** an interfaith workshop is also planned to bring together representatives from the world's churches to discuss steps the churches can take to combat abuse of alcohol and other drugs.

Problems of the developing world will continue to play a major role in the conference, and Mr Archibald said organizers "hope to have significant representation from Third World countries, because this is where the major problems of the future are going to be."

To assist in this goal, a special three-week training session will be held for delegates from The Third World prior to the Congress. The training program is sponsored by the Canadian International Development Agency and will be hosted by the Canadian Addictions Foundation in Edmonton.

The Congress will be hosted by the Alberta Alcoholism and Drug Abuse Commission (AADAC) Tom Wispinski, of the AADAC and Congress Secretariat, says up to 2,000 people are expected to attend.


Archibald


Wispinski

The theme of the conference is Alcohol, Drugs, and Tobacco, An International Perspective — Past, Present, and Future.

Mr Wispinski told **The Journal** approximately 300 presentations will be given during the conference. International speakers will address six major topics: social and public health issues; international and national control policies — aims and realities; perspectives on treatment; prevention strategies; recent advances in knowledge; and themes and future directions.

Youth will take an active role in conference calendar of events

CALGARY — Peer pressure has been regarded as one cause of drug abuse among young people.

But, says the International Council on Alcohol and Addictions, the same peer group pressure could be used positively to promote healthy lifestyles.

"Save a Friend" is the theme of an international drawing competition for youth which is being held here as part of the 34th International Congress on Alcoholism and Drug Dependence in conjunction with the United Nations International Youth Year (The Journal, January).

In Canada, each province will hold a competition, with winning entries coming here for a national competition prior to the Congress. Winning entries from around the world will be on display during the Congress.

In addition, three concurrent sessions discussing youth issues will be included on the program. And, two evening performances by Alberta youth will highlight the Alberta Alcoholism and Drug Abuse Commission's anti-drug campaign theme — Make the most of a good thing. Make the most of you (The Journal, Jan).

Abstract deadline extended

CALGARY — The deadline for submission of abstracts for concurrent sessions at the 34th International Congress on Alcoholism and Drug Dependence has been extended to March 31, says Congress Secretarial Tom Wispinski.

Papers dealing with local, national, and international issues in addictions are welcome. Categories for concurrent sessions include: etiology and prevention; epidemiology and social structures; as well as other research and applied research topics.

One area of special interest, Mr Wispinski told **The Journal**, is historial perspectives on substance abuse.

Research papers presented should be applicable to the practitioner, Mr Wispinski said.

For further information contact: Program chairman, 34th ICAA Congress, #303, 10109-106 St, Edmonton, Alberta T5J 3L7.

The Drinking / Driving Dilemma

– History, Experience, and Strategies –

Legislators and policy-makers in Ontario, across Canada, and internationally, continue to grapple with the drunk-driving dilemma. Recently, the program policy committee of the Addiction Research Foundation developed a document to advise senior-level officials of strategies, shown to be effective through research and experience, for control of the drinking/driving problem. This document is to be circulated to policy-makers, and those who influence policy, primarily in Ontario; as a service to its readers, **The Journal** *has reprinted the advice on these pages.*

SUMMARY

The purpose of this document is to identify the soundest conclusions which can be drawn from research and experience, and to summarize the best advice which the Addiction Research Foundation can offer to those confronted with the task of developing effective strategies for the control of the drinking/driving problem.

1. Measures which increase or decrease the overall level of alcohol consumption in the population are likely to similarly affect the prevalence of impaired driving.

2. To achieve a **lasting** reduction in the prevalence of alcohol problems it will be necessary not only to increase public awareness of alcohol-related hazards but to ensure that complementary changes in control policy occur: **educational efforts and control measures must be mutually reinforcing.**

3. Relaxation of licensing restrictions and other control measures increase the likelihood of drinking and driving.

4. From a public health perspective, alcohol control policy should take into account the probability that a permissive policy respecting the advertising and promotion of alcoholic beverages will have an adverse effect in the long term on the prevalence of alcohol problems, including impaired driving.

5. The effectiveness of legislation prohibiting impaired driving is heavily dependent on the perceptions of drivers of the likelihood of being apprehended. These perceptions, in turn, are influenced by the actual degree of enforcement and the expectation of apprehension generated by complementary public information programs.

6. Ways must be sought to increase the actual and perceived probability of apprehension without a massive increase in the cost of enforcement. There are no unequivocal solutions to this problem in the research literature, but some possibilities which merit investigation in regard to effectiveness, practicality, and acceptability are:

a. Prohibition of **all** drinking in connection with driving.

b. Concentration of enforcement efforts where impaired drivers are most likely to be found.

c. Increasing substantially the awareness of both proprietors of drinking establishments and of the public in general of the civil liability of the former for damage caused to or by impaired persons.

d. Developing a simple alcohol testing device for installation in all motor vehicles. The driver would be required to activate the tester prior to driving. The result would be visible inside and outside the car.

7. Court referral of convicted impaired drivers to treatment or educational programs **when combined with legal sanctions** may reduce recidivism, but is likely to have little impact on the overall prevalence of alcohol-related accidents.

8. All measures that enhance road or vehicle safety in general and are likely to reduce the frequency or severity of traffic accidents deserve support, since such measures have the potential of similarly affecting alcohol-related accidents.

For both the alcohol and the criminal justice fields, the drinking/driving problem poses an unusual dilemma. From the health perspective, most people who have driven while impaired are not alcoholics or problem drinkers in the usual sense of these terms. From the criminal justice perspective, the crime, though serious, does not require intent or a victim. And more people have probably been guilty of it (knowingly or unknowingly) than any other offence in the Criminal Code. At the same time, however, the enormous cost to society is reflected in widespread, often highly vocal, public concern. Not surprisingly, under these circumstances, a considerable body of experience has accumulated as a result of many and diverse attempts to reduce the problem. The objective of the present document has been to identify the soundest conclusions which can be drawn from this experience, and to summarize the best advice which the Addiction Research Foundation can offer to those confronted with the task of developing effective strategies.

Probably as long as there has been an alcoholic beverage and a mode of transportation — whether animal or motor powered — there has been a drinking/driving problem. It was in the mid-1930s, however, that Holcombe's pioneer work convincingly demonstrated that drinking drivers contributed disproportionately to motor vehicle accidents. This seems to mark the beginning of significant social concern calling for study and action. Since then, especially in Europe and America, there has been a concerted and very considerable effort to find ways to reduce the prevalence of impaired driving. Research has revealed much about the magnitude of the problems, methods of detection and quantification, the risks of an accident at different levels of alcohol in the body, which sub-groups of the driving population are at particularly high risk, and the efficacy of diverse countermeasures.

The most important practical outcome of this effort has been the virtually universal adoption in Western World jurisdictions of legal blood alcohol limits for drivers and the use of detection devices to aid enforcement. While these measures are likely to remain essential components of any control system, no countermeasure has yet been applied which results in a *lasting* reduction in alcohol-related accidents. On the other hand, it is possible to draw four conclusions from research to date which should be taken into account in the planning and implementation of any approach intended to have such an effect:

1. It is probable that, unless by some means driving is entirely separated from drinking, measures which increase or decrease the overall level of alcohol consumption in the population will similarly affect the prevalence of impaired driving.

The amount of alcohol consumed in a population is influenced by the degree of social acceptance of use and ease of access to alcohol, the latter being largely determined by the legal control system. The degree of restraint or permissiveness in government control policy is to a considerable extent dictated by social tolerance. While social tolerance may be modified by public information or other educational programs, behavioral change is apt to be minimal unless, or until, changes in the same direction occur in the control system. Thus, to achieve a *lasting* reduction in the prevalence of alcohol problems it will be necessary not only to increase public

(from page 11)
awareness of alcohol-related hazards but to ensure that complementary changes in control policy occur: *education efforts and control measures must be mutually reinforcing*. This view underlies the Foundation's long-term goal with respect to the prevention of alcohol problems in general, and applies as well to the drinking/driving problem.

The absence of mutual reinforcement is well illustrated by the situation in Ontario during the past 30 years. While health educators and others have sought to increase public awareness of the hazards of heavy alcohol use, and most particularly of those associated with drinking and driving, there has been a steady increase in accessibility of alcohol through relaxation of controls. Examples of changes which had, or may potentially have, an adverse effect on efforts to reduce impaired driving include lowering the legal drinking age, and increased permissiveness with regard to the distribution of licensed drinking places and to advertising by the alcoholic beverage industry. Lowering the drinking age from 21 to 18 apparently resulted in increased alcohol consumption by the age group affected, and certainly resulted in an increase in their alcohol-related accidents. Likewise, the large increase permitted in outlets licensed for on-premise consumption over the period, and the absence of relevant restrictions on location, have resulted in taverns and other drinking places on or near highways. It would seem an inescapable conclusion that such licensing encourages drinking and driving.

The Foundation has for some years taken the view that the relatively permissive attitude of government toward alcoholic beverage advertising is highly undesirable. While the results of studies of the impact of advertising, or different forms of advertising, on alcohol consumption have been either equivocal or negative, no research has yet attempted to deal with the crucial, and perhaps unanswerable, question of long-term impact: that is, the effect of growing up in a world where frequent exposure to alcohol advertising is inescapable.

In any event, it is important to recognize that control measures carry a message. The public has long accepted a governmental role in health protection and relevant legal constraints as a consequence. Accordingly, permissiveness in the alcohol area inevitably conveys the view that alcohol consumption is harmless or less harmful than once thought. In the case of advertising, a liberal policy carries the message that government considers it safe to permit greater attention to be drawn to the product. In addition, advertising commonly portrays alcohol use as a natural and desirable part of everyday life. Thus, increased social tolerance is doubly reinforced.

A recent study* of the trade journals of the brewing and wine industries in the United States has shown that "normalization" of their products is an explicit objective, and that their share of the total beverage market has increased in recent years: "It appears that when alcohol industry executives talk about increasing their market share, they are thinking about the total beverage market, including water, soft drinks, juices, milk, coffee, tea, etc. The sellers of Riunite, a sweet, white wine marketed much like beer, put it plainly: 'Today we consider any liquid at all our competition. We are positioning ourselves like a soft drink.' (*Business Week*, March 15, 1982). In the US, alcoholic beverages have increased to 21% of the total beverage market by volume in 1978 from 15% in 1960, a share projected to rise to 25% by 1990 (*Impact*, January 15, 1979, October 15, 1979)." The extensive lifestyle advertising in Canada, particularly by the brewers, clearly implies a similar objective.

The Foundation believes that public health consequences should be a major consideration in formulating all alcohol control policies. At the same time, however, it will probably always be essential to foster the developing and implementation of countermeasures specifically aimed at drinking/driving or at traffic safety in general. The remaining three conclusions of research on the problem to date concern such countermeasures.

2. The effectiveness of legislation prohibiting impaired driving is heavily dependent on the perceptions of drivers of the likelihood of being apprehended. These perceptions, in turn, are influenced by the actual degree of enforcement and the expectation of apprehension generated by complementary public information programs.

The possibility that very severe penalties would reduce the frequency of impaired driving cannot be ruled out. However, such increases in severity as would be socially acceptable at present are likely to have little impact in the absence of heightened expectations of apprehension and conviction on the part of the drivers.** The latter is probably best achieved through increasing the effectiveness and efficiency of the enforcement apparatus combined with a vigorous public information program to draw attention to the activities involved. This effort might include, in particular, training programs for the police to improve their ability to identify impaired drivers, simplification of arrest and adjudication procedures to increase the number of convictions, and random roadside screening.

There is little doubt that random roadside screening, if sufficiently intensive, is the most effective means available to increase driver expectation of apprehension and reduce impaired driving. However, it is probably not practicable for both financial and political reasons to sustain the required level indefinitely in order to achieve a lasting effect. The question, therefore, becomes: Are there acceptable ways to increase the actual and perceived probability of apprehension without a massive increase in the cost of enforcement? There are no unequivocal solutions to this problem in the research literature, but possibilities which merit investigation in regard to effectiveness, practicality, and acceptability are:

(a) Prohibition of all drinking in connection with driving, ie, a minimum blood alcohol level would not have to be demonstrated to secure a conviction. Clearly this would simplify both enforcement and adjudication; only qualitative test evidence of the presence of alcohol would be required;

(b) Concentration of enforcement efforts where impaired drivers are most likely to be found, eg, in the immediate vicinity of public drinking places;

(c) Increasing substantially the awareness of both proprietors of drinking establishments and of the public in general of the civil liability of the former for damage caused to or by impaired patrons. Probably this would require as a minimum a deliberate communication program under the auspices of the Attorney General and the Liquor Licence Board of Ontario;

(d) Developing a simple alcohol testing device for installation in all motor vehicles. The driver would be required to activate the tester prior to driving. The result would be visible inside and outside the car, for example, in the form of a red or green light, depending on the presence or absence of alcohol. Theoretically, this would eliminate the need for *random* roadside screening.

An important problem in regard to countermeasures of this type is *a priori* rejection on grounds of social unacceptability. Accordingly, it would be advisable to determine the extent of public support for a more stringent approach to the problem through a province-wide survey. If such a survey were conducted under government auspices, it might well have educational value in its own right, in that the importance of finding a solution would be emphasized.

3. Court referral of convicted impaired drivers to treatment or educational programs *when combined with legal sanctions* may reduce recidivism, but is likely to have little impact on the overall prevalence of alcohol-related accidents.

The results of evaluation studies of efforts to rehabilitate impaired drivers suggests that education and treatment programs may have beneficial effects on subsequent driving behavior. Positive changes in knowledge and attitudes have been found consistently, and a majority of the quasi-experimental and about half the experimental studies have also reported improvements in driving behavior. However, such programs have often been employed, in effect, as substitutes for legal sanctions: the bargaining tools to induce drivers to participate in the program. Current information indicates that this practice is probably undesirable. Legal sanctions have an important positive impact on driving behavior which might be increased by a rehabilitation program but which might not be achieved, or not to the same extent, by the program alone. *Therefore, the rehabilitation approach should be seen as a supplementary strategy and not as a replacement for legal sanctions.*

While the available evidence suggests that rehabilitation programs may have a beneficial impact on subsequent driving behavior, it is not possible to state with any certainty which types of program are most effective. This problem is compounded by the fact that the programs employed are usually not described in any detail. Furthermore, it is important to recognize that most programs do not appear to have been particularly successful in modifying lifestyle, probably the most significant indicator of an effective program.

Finally, rehabilitation programs, even if successful, cannot be expected to have more than a small effect on prevalence since the vast majority of those convicted in any given year are first offenders. Accordingly, further large-scale investment in this approach is probably not cost-effective, and may divert attention and resources from promising, primary preventive efforts.

4. All measures that enhance road or vehicle safety in general and are likely to reduce the frequency or severity of traffic accidents deserve support, since such measures have the potential of similarly affecting alcohol-related accidents.

In addition to approaches specifically focused on the drinking driver, the Foundation supports all measures that enhance road safety, and are likely to reduce the frequency or severity of accidents. These measures include, for example, improved road design, mandatory safety devices such as seat belts and passive restraints, development of safer vehicles, programs to improve driving behavior, and stringent enforcement of traffic regulations.

---

*McBride, R. Competition, Marketing, and Regulatory Issues in the Beer Industry. Paper presented at the 40th Conference of the National Council on Alcoholism, Detroit, 1984.

**A factor which may be in the process of altering acceptance in favor of more severe penalties and/or more stringent enforcement methods is the rise of highly vocal pressure groups comprising relatives of people killed or injured by impaired drivers. It has recently been suggested that the deliberate organization of such groups might be an effective route to social change (F. Klajner et al. Prevention of Drunk Driving. In: Prevention of Alcohol Abuse; P.M. Miller & T.D. Nirenberg [Eds.]. New York: Plenum 1984, 462 p et seq).

Police now call cabs for drunken motorists in BC

Court blocks roadside licence suspensions

By Tim Padmore

VANCOUVER — Police officers in British Columbia went through the holiday season this year without one of their favorite weapons against drinking drivers: the 24-hour roadside licence suspension.

The provincial Motor Vehicle Act has provided that if a police officer suspects a motorist has been drinking he can offer the motorist a choice of a breath-analysis test, which could lead to a charge of impaired driving, or an immediate 24-hour suspension.

But last summer, the BC Supreme Court ruled that the law is "an unlawful infringement" of the right, guaranteed under the Canadian Charter of Rights and Freedoms, to "life, liberty, and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

The court objected to the fact that the law does not require any connection with the consumption of alcohol or inability to drive safely — only an officer's suspicion.

The provincial attorney-general appealed the decision at a hearing last December, arguing that although the literal wording of the law allows extremely broad application, the court should construe the law to avoid "a ridiculous result."

The appeal court justices have reserved judgment, but commented during the hearing that the law could easily be rewritten to make it say what legislators intended and that the court should not be asked to "bend" the words of the law.

Police liked the law because roadside suspensions could be handed out in a matter of minutes, while charging a motorist with impaired driving takes up to two hours.

Vancouver police handed out 5,650 roadside suspensions in 1983 and 2,520 more in the first half of 1984, about 2½ times the number of impaired driving charges.

This past Christmas, police in Vancouver and Victoria said they were pressing motorists who might once have received roadside suspensions to take a cab home. In Victoria, the police dispatcher called the cabs for the motorists.

"It's for drivers who've had a couple of belts, probably aren't legally impaired, but whose driving ability is affected," said Victoria Constable Dave Kuzina.

Despite the legal setback, progress appears to have been made in the battle against drunk driving. The attorney-general reported in December that the percentage of alcohol-related casualties is lower than at any time in the past nine years.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000 ext 7384.

Promises: Profile of an Alcoholic

Number: 630.
Subject heading: Alcohol and the family.
Details: 30 min, color.
Synopsis: Michael is an actor and a producer. One night at dinner his wife, an actress, asks him not to drink so much. She recounts several incidents in which his drinking has interfered with parties and work. Michael promises to cut back, but later misses a dress rehearsal for his new play. On opening night, Michael promises to drink only one glass, and be home soon. However, he does not manage either. Next morning he apologizes and throws away all his remaining alcohol. His wife, however, insists that they seek help at a treatment centre. Michael is offered a bed immediately but uses many excuses to avoid treatment. After another episode, his wife confronts him, gives him an ultimatum, packs his bag, and takes him to the treatment centre.
General evaluation: Good (4.0). This contemporary film had a clear message and was judged a good teaching aid about early intervention in drinking problems. General broadcast was recommended.
Recommended use: General audiences.

The Sorrows of Gin

Number: 638.
Subject heading: Alcohol and the family.
Details: 60 min, color.
Synopsis: Amy is about six years old. She lives with her wealthy parents who have cocktail parties and go out frequently. Their new maid tells Amy that her (the maid's) sister died because she drank too much, and urges Amy to pour out her father's gin so that he won't drink so much; the maid is fired when she returns, drunk, from her day off. Amy pours away a bottle of gin; the next maid is accused of drinking it and is fired. One night, while her parents are out again, Amy pours out another bottle of gin. This time the babysitter is accused of drinking it, and an argument erupts. Amy decides to run away, but the railway station master calls her father to come and get her.
General evaluation: Poor to fair (2.6). The assessment group believed there was no clear message in this film and that the lifestyle of the family portrayed was unrealistic for the majority of the population.
Recommended use: General adult audiences.

Choices: Alcohol, Drugs or You

Number: 640.
Subject heading: Drugs and youth.
Details: 20 min, color.
Synopsis: Bill is on his way to see Roxanne. He has had a few drinks to reduce his tension. Suddenly he is "transported" to a video parlor and told to play the game of Choices. He sees the story of Shelly who had been taking pills and drinking. After several bad episodes, Shelly gets help and now seems to be better. The next game is with Slick who manages a rock band, smokes PCP (phencyclidine), and looks after his drinking father. Slick plans a birthday celebration for his father, who fails to come home. Slick smokes more PCP, hallucinates, puts his hand through the window, then falls, hitting his head on a chair just as his father comes in. Bill is the subject of the third game; he started drinking to feel more at ease with girls, and almost lost his place on the school football team — now he has a choice between drinking and playing football.
General evaluation: Fair (3.4). While the message and situations portrayed could lead to good discussion, the acting seemed amateurish and the video-game setting contrived.
Recommended use: With a resource person, this program could be used with audiences aged 12 to 18 years.

NEWS AND DEPARTMENT

Bagful of steroids lands conviction for Manitoba muscleman

By Maureen Brosnahan

WINNIPEG — A former "Mr Manitoba" has been convicted of possessing a large amount of anabolic steroids and other performance-enchancing drugs for the purpose of selling them to other athletes.

In only the third case of its kind in Canada, Gregory John Jackson, 25, pleaded guilty recently to six counts of possession for the purpose of selling under the federal Food and Drugs Act.

Mr Jackson was fined $3,000 and placed on one year's unsupervised probation, federal crown attorney Judith Webster said.

The case arose after Mr Jackson left an athletic bag containing 158 vials and 2,418 tablets of six different kinds of anabolic steroids and other drugs in a locker at the University of Manitoba here.

After a day, the locker was opened by university officials and the drugs were discovered. Police were called at the same time Mr Jackson showed up to claim the bag.

The bag contained some papers and price lists for the drugs. Among the drugs discovered were testosterone, Anavar (oxandrolone), Anadrol (oxymetholone), and androstanolone, all used to increase muscle weight and build tissues.

Some of the drugs have a street value of 3½ times that of the legitimate pharmacy price, according to a spokesman from the Manitoba Pharmaceutical Association.

While these drugs are used legitimately to treat patients with growth problems, studies show they can cause side effects such as sterility in men and infertility in women.

Ms Webster told **The Journal** this case, and a recent one in Quebec involving two Soviet athletes, have opened the door to future legal cases.

She said it is not considered illegal to have these drugs because they are not classified as narcotics. However, she said it is illegal to sell any drugs which can be obtained legally only through a prescription.

"There's no crime in possessing the stuff. It's when you're selling it that you get into trouble," she said.

Last year, the College of Physicians and Surgeons of Manitoba reprimanded two doctors after they were found to be prescribing anabolic steroids and growth hormones to athletes.

The case was discovered when claims for the drugs were submitted to the provincial pharmacare program. As a result, the College warned all doctors that they should not prescribe these drugs for athletes since enhancement of athletic performance is not a medical condition requiring treatment.

Wayne Hildahl, MD, director of sports medicine at Winnipeg's Red-Fit Centre, said the College's directive has virtually dried up the legal source for these drugs, causing the black market to flourish.

Several experts said that it is not unusual to see some athletes going around from gym to gym offering these drugs for sale.

As well, use of the drugs has become socially acceptable among athletes, they said.

"Sometimes you can even catch them shooting themselves (up) in the locker room," said one athlete, who said he believes such drugs should be used only under medical supervision.

Dr Hildahl told **The Journal** most of the drugs are coming here from the United States and Mexico. "I think there's a lot of money to be made in it."

While the drugs do have an effect on muscle mass, Dr Hildahl said, he does not support their use by athletes. The Manitoba Medical Association has also taken this stand.

NB commission broadens reach

By John Carroll

FREDERICTON — The New Brunswick Alcohol and Drug Dependency Commission (ADDC) broadened its reach during fiscal year 1983-84, on the heels of a major reorganization.

According to its recent annual report, educational services under the new Community Services Division (CSD) continued as a high priority. The expanded CSD mandate saw the provision of programs for special groups — women, the elderly, the disabled, Native people, clergy, and the medical profession. The division is also responsible for judiciary programs, including the Short, High Impact Program for first-time impaired drivers.

The ADDC staff maintained close cooperation with the educational system. Beyond school programs, the division coordinated its second Safe Grad program (**The Journal**, Jan). The CSD made presentations to nearly 6,800 educators, students, and members of youth organizations.

The reorganization saw the creation of the Support Services Division, encompassing a full range of information services, including a 1,000-item library.

The Treatment and Rehabilitation Division's 1983-84 client profile shows 3,437 men and 579 women sought detoxification or rehabilitation help — increases of 3.75% and 7.25% respectively. As in previous years, the majority of patients were in the 30 to 39 age group, with a 27.1% share of the total. This was followed by 22% in the 40 to 49 age group, 18% 50 to 59, and 17.7% 19 to 29 years.

During the year, employee assistance programs (EAPs) made considerable progress. Several organizations, including major public and private sector employers, adopted policies and, at year-end, 41 EAPs were in place across the province. Nearly 3,600 employers and employees participated in public presentations.

In addition, the ADDC negotiated contracts with the federal government for rehabilitation and assessment programs for penitentiary inmates prior to release.

The total ADDC budget was $5,872,977.

CPDD focus is shifting to include alcohol concerns

TORONTO — The Committee on Problems of Drug Dependence (CPDD) is again seeking scientific papers on all aspects of alcohol abuse.

"In continuation of the policy established last year, the CPDD, which has traditionally been interested in narcotic drugs, is now inviting a much broader participation from researchers and clinicians in the alcoholism field," says Harold Kalant, MD, PhD, director of neurobiology at the Addiction Research Foundation (ARF) here.

Dr Kalant, who is the ARF's permanent liaison with the committee, told **The Journal** the call for papers is open to all areas of alcoholism and other drug dependence and can range from basic research to policy.

The 47th Annual Scientific Meeting of the CPDD will be held June 10-12 in Baltimore, Maryland, in conjunction with the 50th anniversary of the Addiction Research Centre (ARC), and the dedication of the ARC's new facility at Johns Hopkins University, Baltimore. The ARC is supported by the United States National Institute on Drug Abuse and was formerly located in Lexington, Kentucky.

In addition, Dr Kalant said the CPDD is seeking nominations for two special awards presented by the committee each year: the Eddy Award for outstanding contribution to the field of drug dependence, and the Morrison Award for outstanding service as a research administrator.

For further information contact: Joseph Cochin, MD, executive secretary, CPDD, department of pharmacology, Boston University School of Medicine, 80 Concord St, Boston, Massachusetts, 02118.

New Books by RON HALL

Social and Medical Aspects of Drug Abuse

. . . edited by George Serban

This book attempts to define a new approach to drug addiction based on a biopsychosocial model in which all the components of human interaction with the environment are integrated and attacked simultaneously. The individual has to feel that society will help him solve his problems, but will not carry him on his terms because he has labelled himself as, and acts out as, a drug user. In one chapter, a brief chronological review of the discoveries and developments of opiate receptors and opioid peptides is provided and recent research that bears on the possible involvement of the endogenous opioid system in drug addiction is summarized. Another chapter presents a review of research into conditional taste aversions which was aimed at clarifying its relevance to drug dependence, and to understanding how drugs could apparently serve multiple stimulus functions depending on the circumstances surrounding their administration. Other chapters deal with an examination of the volitional disorders, the maintenance of behavior by schedules, endocrine and immunological observations in heroin and methadone-maintained opioid addicts, behavioral factors in drug dependence and withdrawal, the epidemiology of the heroin crisis, the clinical pharmacology and therapeutic use of naltrexone, methadone maintenance programs, and empirical patterns of heroin consumption among selected street heroin users.

(SP Medical and Scientific Books, 175-20 Wexford Terrace, Jamaica, NY 11432, 1984. 244 p. $40. ISBN 0-89335-191-1)

Others books

Getting Over Getting High — Green, Bernard. William Morrow and Company, New York, 1984. How to overcome dependency on cocaine, caffeine, hallucinogens, marijuana, speed, and other stimulants the natural and permanent way; index. 265p. William Morrow and Company, 105 Madison Ave, New York, NY 10016. $6.95. ISBN 0-688-03949-9.

Substance Abuse Book Review Index 1983 — Bemko, Jane. Addiction Research Foundation, Toronto, 1984. Citations of 226 book titles and corresponding journal references to book reviews; more than 250 journals scanned annually for book reviews; author, subject, and title indexes. 67p. Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1. $6.95. ISBN 0-88868-098-8.

Drugs, Drinking, and Adolescents — Macdonald, Donald Ian. Year Book Medical Publishers, Chicago, 1984. Drug epidemic; stages of drug use; "do-drug" messages; peer pressure; parent revolution; diagnosis; treatment; prevention through laws and education; areas of controversy; role of the physician; index. 258p. Year Book Medical Publishers, Chicago, IL. ISBN 0-8151-6550-1.

Deterring the Drinking Driver: Legal Policy and Social Control — Ross, H. Laurence. DC Heath, Toronto, 1984. The problem; deterrence model; methods for studying deterrence; Scandinavian-type laws; law enforcement; index. 137p. DC Heath, Suite 1600, 100 Adelaide St W, Toronto, ON M5H 1S9. $15.95. ISBN 0-669-08199-X.

Personal Skills Training for Problem Drinkers — Williamson, Pip, and Norris, Hugh (eds). Alcoholics Rehabilitation Research Group, Birmingham, 1984. A counsellor's guide; personal skills training; methodological background; functional models of drinking; recovery process; contracts; personal skills training counselling groups; controlled drinking; place of individual counselling; counselling program; suitable clients; skills required. 95 p. Aquarius, 41 Newhall St, Birmingham, B3 3QD, England. £6. ISBN 0-9509723-0-4.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:

a) Regular Line Rates — $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) — $1,000
½ Page (560 lines) — $500
¼ Page (280 lines) — $250
c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation 27,318 (Canada, 21,412, USA, 1,907, Foreign, 386, Bulk, 3,613)
Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents $16 per year
USA & Foreign Residents $24 per year

Bulk Subscription Rates
Purchase of 5 or more subscriptions mailed to the same address — 20% discount
Ontario residents billed as other Canadians

The Journal, 33 Russell St
Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Relaxation and Stress Management Course — March 7-8, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation (ARF), 8 May St, Toronto, ON M4W 2Y1.

1985 National Health Care Management Conference — March 13-15, Toronto, Ontario. Information: Professional and Management Development, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Family Intervention Workshop for Health-Care Professionals — March 20, Toronto, Ontario. Information: Yvonne Johns, The Donwood Institute , 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Management for Supervisors in the Health Care Setting — March 20-21, Toronto, Ontario, April 23-24, Winnipeg, Manitoba, May 6-7, Quebec City, Quebec. Information: Ingrid Norrish, program manager, Professional and Management Development, Humber College, Box 1900, Rexdale, ON M9W 5L7.

Behavioral Interventions Course — March 27-29, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

2nd Annual Symposium — Designing World Class Health Promotion Programs for Canadians — April 14-21, Burnaby, British Columbia. Information: Kros Cancer Society, 42 Begbie St, New Westminster, BC V3M 3L9.

Symposium 85: Focus on Therapy — April 15-19, Toronto, Ontario. Information: Cynthia Rasky, Metatron, 53 Lisa Cres, Thornhill, ON L4J 2N2.

Suicide — A Critical Perspective — American Association of Suicidology — April 18-21, Toronto, Ontario. Information: Rev Gordon Winch, Council on Suicide Prevention, 10 Trinity Square, Toronto, ON M5G 1B1.

Alcohol and the Family Workshop: Community Program Approaches — May 6-7, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Marital and Family Therapy Course — May 8-10, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Catholic Health Association of Canada Annual Convention — May 15-17, Banff, Alberta. Information: Catholic Health Association of Canada, 312 Daly, Ottawa, Ontario K1N 6G7.

Alcohol, Other Drugs and the Law Course — May 22-24, London, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto ON M4W 2Y1.

Parent Resources Institute for Drug Education (PRIDE-CANADA INC) 1st Annual National Conference — May 30-June 1, Saskatoon, Saskatchewan. Information: Ruth Kell, convenor, PRIDE-CANADA, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

85th Annual Meeting of the Canadian Lung Association, and the Annual Scientific Meetings of the Canadian Nurses' Respiratory Society, and the Physiotherapy Section of the Canadian Lung Association — June 2-5, Ottawa, Ontario. Information: A. Les McDonald, health education coordinator, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, ON K1P 5E7.

Advanced Clinical Social Work Certificate Program — June 17-28, Toronto, Ontario. Information: Allen Cutcher, School of Continuing Studies, University of Toronto, 158 St George St, Toronto, ON M5S 2V8.

International Convention of Alcoholics Anonymous — July 4-7, Montreal, Quebec. Information: International Convention, Box 1985, D, Buffalo, New York 14210.

26th Annual Institute on Addiction Studies — July 14-19, Hamilton, Ontario. Information: Kathryn Irwin, course administrator, Alcohol and Drug Concerns Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer School for Addiction Studies — July 15-26, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-10, Calgary, Alberta. Information: Jan Skirrow, Chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

Canadian Addictions Foundation Annual General Meeting — Aug 5, Calgary, Alberta. Information: Leona Gelger, Canadian Addictions Foundation, Pacific Plaza, Box 702, 10909 Jasper Ave, Edmonton, AB, T5J 3M9.

Royal College of Physicians and Surgeons of Canada — 54th Annual Meeting — Sept 9-12, Vancouver, British Columbia. Information: Royal College of Physicians and Surgeons of Canada, Robert A. Davis, coordinator, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

The Canadian Thoracic Society and the Medical Section of the Canadian Lung Association, conjointly with the Royal College of Physicians and Surgeons — Sept 9-12, Vancouver, British Columbia. Information: A. Les McDonald, health education coordinator, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, ON K1P 5E7.

Annual Meeting of the Canadian Society of Forensic Science — Sept 20-27, Montreal, Quebec. Information: executive secretary, Canadian Society of Forensic Science, 2660 Southvale Cres, Ste 215, Ottawa, Ontario K1B 4W5.

1985 Ontario Occupational Health Nurses Association Conference — Nov 4-8, Toronto, Ontario. Information: B.J. Varey, publicity committee chairperson for Conference 85, c/o Sun Life of Canada, 3rd fl, 150 King St W, Toronto, ON M5H 1J9.

United States

8th Annual Alcoholism Symposium, Strategies and Objectives for Treatment Interventions — March 9, Boston, Massachusetts. Information: Douglas Jacobs, director, continuing education division, The Cambridge Hospital, department of psychiatry, 1493 Cambridge St, Cambridge, MA 02139.

Alcohol and Drug Problems Association of North America's National Management Issues Conference: Service Delivery in the 80s — March 10-12, Austin Texas. Information: Eric Scharf, ADPA, 444 Capitol St, NW, Washington, DC 20001.

Drugs in the Workplace — March 24-26, New York, New York. Information: The US Journal Training, 2119-A Hollywood Blvd, Hollywood, Florida 33020.

NECAD — Northeastern Conference on Alcoholism and Drug Dependence — March 24-27, Newport, Rhode Island. Information: Edgehill-Newport Foundation, Beacon Hill Road, Ste 106, Newport, RI 02840.

Texas EAP Symposium V: Merging Individual Needs with Organizational Growth —March 24-27, Austin, Texas. Information: Robby Duffield, conference coordinator, Texas Commission on Alcoholism, 1705 Guadalupe, Austin, TX 78701.

Alcoholism and Drug Abuse: Problems in Clinical Decision-Making — April 10-13, New York, New York. Information: Dr Elizabeth C. Gerst, Continuing Education Center, 630 168th St, New York, NY 10032.

The National Nurses Society on Addictions — April 14-17, Arlington, Virginia. Information: NNSA, 2506 Gross Point Rd, Evanston, Illinois 60201.

National Alcoholism Forum of the National Council on Alcoholism — April 18-21, Washington, DC. Information: Angela Heather Masters, NCA, 12 W 21st St, 7th fl, New York, New York 10010.

16th Annual Medical-Scientific Conference of the National Council on Alcoholism — April 18-21, Washington, DC. Information: Louisa Macpherson, American Medical Society on Alcoholism, 12 W 21st St, 7th fl, New York, New York 10010.

The American Orthopsychiatric Association, Inc 62nd Annual Meeting — April 20-24, New York, New York. Information: American Orthopsychiatric Association, 19 W 44th St, Ste 1616, New York, NY 10036.

1st Annual Pacific Regional Alcohol and Drug Education: "Visions for Tomorrow — Prophets, Profits or Chaos," — April 22-24, San Diego, California. Information: Jeff Cole or Meri Beth Ring, Hillside Hospital, 1940 El Cajon Blvd, San Diego, CA 92105.

Children of Alcoholics — April 25-26. Milwaukee, Wisconsin. Information: Jennifer Gordon, training department, De Paul Rehabilitation Hospital, 4143 13th St, Milwaukee, WI 53221.

PRIDE International Parents Conference on Drugs — April 25-27, Atlanta, Georgia. Information: PRIDE, 100 Edgewood Ave, Ste 1216, Atlanta, GA 30303.

189th American Chemical Society National Meeting — April 28-May 3, Miami, Florida. Information: Dr M. H. Ho, department of chemistry, University of Alabama, Birmingham, Alabama 35294.

COSA/85, The 6th Conference on Substance Abuse — May 1-3, Cincinnati, Ohio. Information: Ann Blankenhorn, alcoholism consultant, Consultation and Education, Central Community Health Board of Hamilton County, Inc, 520-532 Maxwell Ave, Cincinnati, OH 45219.

Central Region Conference of the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) — May 7-10, St Louis, Missouri. Information: Della Kinsolving, c/o St Elizabeth Medical Center, 2100 Madison Ave, Granite City, Illinois 62040.

4th Conference on Alcoholism and the Family — May 22-26, Philadelphia, Pennsylvania. Information: The Caron Foundation, Box 277, Galen Hall Rd, Wernersville, PA 19565.

Committee on Problems of Drug Dependence 47th Annual Scientific Meeting — June 10-12, Baltimore, Maryland. Information: Dr Joseph Cochin, executive secretary, Committee on Problems of Drug Dependence, department of pharmacology, Boston University School of Medicine, 80 E Concord St, Boston, Massachusetts 02118.

Summer Institute on Child Development and Social Policy — June 15-28, Austin, Texas. Information: Washington Liaison Office, Society for Research in Child Development, 100 North Carolina Ave, SE, Ste 1, Washington, DC 20003.

Reflections on Family Therapy — June 23-26, St Paul, Minnesota. Information: conference coordinator, Family Therapy Institute Inc, 790 Cleveland Ave S, St Paul, MN 55116.

16th Annual International Narcotic Research Conference — June 23-28, Seacrest, Massachusetts. Information: E. Leong Way, department of pharmacology, University of California, San Francisco, California 94143.

36th Annual Symposium on Alcoholism — June 24-July 5, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, Seattle, WA 98122.

36th Annual Conference of the Alcohol and Drug Problems Association of North America —"Confronting the Issues — Challenges for the 80s" — Aug 18-21, Washington, DC. Information: Eric Scharf, ADPA, 444 N Capitol St, Ste 181, Washington, DC 20001.

International Youth Services Conference — Oct 6-9, Chicago, Illinois. Information: Bill Treanor, executive director, American Youth Work Center, 1346 Connecticut Ave NW, Ste 925, Washington, DC 20036.

National Federation of Parents for Drug-Free Youth, 4th Annual Conference — Nov 6-9, Washington, DC. Information: Mary Jo Green, NFP, 1820 Franwall Ave, Ste 16, Silver Spring, Maryland 20902.

Association of Labor-Management Administrators and Consultants on Alcoholism, 14th Annual Conference — Nov 10-14, Boston, Massachusetts. Information: Judith Evans, associate director, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

Association for Medical Education and Research in Substance Abuse, 9th Annual Conference — Nov 14-15, Washington, DC. Information: Dr G. Lewis, AMERSA president, Center for Alcohol Studies, Brown University, Box G, Providence, Rhode Island 02912.

Abroad

International Symposium on Alcohol Problems — May 18-19, Madurai, India. Information: S. Selvin Kumar, Blue Cross Society of India, Palkalai Nagar, Madurai-21, India.

Scandinavian Study Tour on Drinking and Driving and Alcohol Policy — May 24-June 8, Oslo, Stockholm, Helsinki, Copenhagen. Information: Camilla Colantonio, department of conferences, Nolte Center, 315 Pillsbury Dr SE, University of Minnesota, Minneapolis, Minnesota 55455.

10th Congress of the International Association for Accident and Traffic Medicine (IAATM) — May 27-31, Tokyo, Japan. Information: 10th Congress of the IAATM, secretariat, International Congress Service, Inc, Chikusen Bldg 5F, Nihonbashi 2-7-4, Chuo-ku, Tokyo 103, Japan.

31st International Institute on the Prevention and Treatment of Alcoholism — June 2-7, Rome, Italy. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

Social Work Goes to London —June 22-29, London, England. Information: Ann Boehme, continuing education coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042.

International Youth Forum on Alcohol and Drugs — July 9-12, Cardiff, United Kingdom. Information: Dr Myrddin Evans, Addiction Unit, South Glamorgan Health Authority, Whitchurch Hospital, Whitchurch, Cardiff, CF4 7XB, United Kingdom.

1985 World Congress on Mental Health — July 14-19, Brighton, England. Information: Barbara Poole, World Congress organizer, 22 Harley St, London, England W1N 2ED.

3rd International Conferenec on Alcohol and Drug Abuse — Aug 11-14, Lima, Peru. Information: Dr. L. Vasquez, International Education, Peruvian College of Physicians, Wadsworth, Illinois 60083.

2nd National Drug Institute — Alcohol and Drug Use in a Changing Society — Aug 14-16, Darwin, Northern Territory, Australia. Information: Chairman, NDI Planning Committee, Drug and Alcohol Bureau, Northern Territory department of health, GPO Box 1701, Darwin NT 5794 Australia.

4th European Acupuncture and Alternative Medicine Symposium and World Symposium on Moratherapy and Lasertherapy — Aug 30-Sept 1, Copenhagen, Denmark. Information: secretary general, Scientific Committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

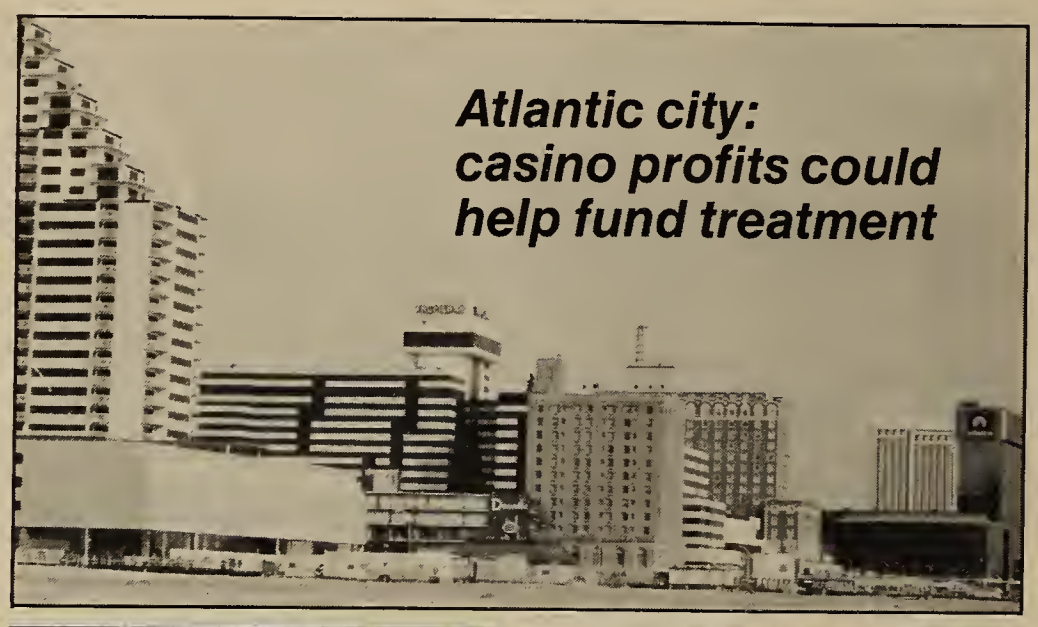
12th International Conference on Health Education — Sept 1-6, Dublin, Ireland. Information: Dr H. D. Crawley, director, Health Education Bureau, 34 Upper Mount St, Dublin, Ireland.

Seminar on Addiction 2 — Sept 5-15, Madrid, Cordoba, Seville, Marbella, Costa Del Sol, Spain. Information: Millglen Medical Corporation, PO Box 888673, Atlanta, Georgia 30356.

1st World Congress on Drugs and Alcohol — Dec 15-19, Tel Aviv, Israel. Information: congress secretariat, Peltours Ltd, Congress department, PO Box 394, Tel Aviv 61003, Israel.

Glamors of gambling hooking high rollers

Lynn Payer reports



Atlantic city: casino profits could help fund treatment

ATLANTIC CITY, NJ — On an average day, more than 900 buses from neighborhoods throughout the eastern seaboard of the United States arrive here. It's "a city where nine Taj Mahals flourish in the midst of a war zone," in the words of one legislator.

The Taj Mahals, of course, are the nine (and now 10) casinos which have opened since gambling was legalized in 1976; the war zone is the rest of Atlantic City, whose promised revival was the selling point that convinced the residents of New Jersey to authorize casinos here.

Several of the 900 buses leave from my rather unfashionable neighborhood in Manhattan. One Tuesday, early in December, I chose the Trailways, which dropped us at the Tropicana, where a version of the Hallelujah chorus was playing through speakers in the foyer.

Tickets for the round trip cost $15.50, with $10 in coins given back to each passenger. Such day-buses carried 11 million people in 1983, and are making Atlantic City the most visited resort in the United States. The gross income of the 10 casinos, around $10 billion, is predicted to surpass that of the 90 Las Vegas casinos any day now.

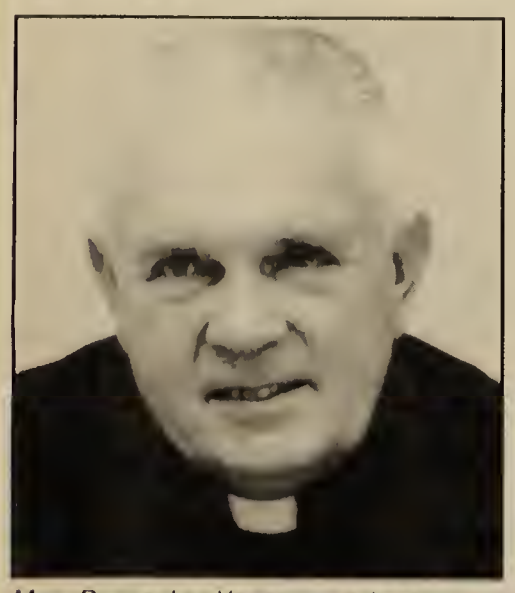
"Las Vegas has moved east," said Monsignor Joseph A. Dunne, president and executive director of the National Council on Compulsive Gambling, Inc, based in New York City. Others say that Atlantic City can now claim the title of "Gambling Capital of the World."

* * * * *

New Jersey was the first state outside of Nevada to authorize casinos, but the trend to legalize various forms of gambling is a national one, with only two states, Utah and Indiana, not having some form of legal gambling, Msgr Dunne told **The Journal**.

Legislators often see legalized gambling, usually in the form of a lottery, as a relatively painless way to raise revenues without unpopular taxes. One problem, according to the book *The Atlantic City Gamble*, by George Sternlieb and James W. Hughes (Harvard University Press, 1983) is that since money gambled by state residents is not nearly so valuable to the state as that gambled by out-of-state residents, the revenues from state gambling are dependent upon neighboring states *not* legalizing gambling.

Another problem, points out Msgr Dunne, is that legalized gambling tends to increase, not decrease, the amount of illegal gambling, thus increasing the influence of organized crime.



Msgr Dunne: Las Vegas moved east

THE BACK PAGE

The number of Gamblers Anonymous groups has more than doubled in New York since Off-Track Betting was legalized and more than tripled in New Jersey since the advent of casinos in 1978. Gamblers who become hooked on legal gambling, claims Msgr Dunne, will turn to illegal gambling because of its phone connections and easier credit.

* * * * *

A semiotician (student of signs and symbols) would have a field day at the casinos; every detail is studied to increase revenues. One casino, for example, had its cocktail waitresses dressed in bunny suits; bad, apparently, because they attracted more gawkers than high rollers.

The Golden Nugget, whose decor might be described as 1890s Colorado, accented with Greek statues, is apparently onto something. It is Atlantic City's most profitable casino per surface area, roughly 100 times more profitable per square foot than a shopping centre. And the square footage is considerable; the second-floor ladies' room is bigger than most houses.

But despite touches of individuality, the casinos all seem to share the hurly-burly atmosphere of noise and lights, distinctly different from the quiet elegance of European casinos such as Baden-Baden in Germany. And, while croupiers at Baden-Baden are not above a bemused smile at non-gambling visitors, those at Atlantic City do not allow anything that detracts from the extremely serious business of high rolling.

Coins are not accepted for the table games, and neither is my willingness to bet three dollars on Blackjack in order to learn the game. At the Golden Nugget, the annoyed croupier advises me to buy a book, and the equally annoyed croupier at the Tropicana tells me I will surely lose. The implication is that gambling takes skill, intelligence, and practice. Undaunted, I wager three dollars. I lose, but fail to understand how skill, intelligence, and practice would have kept the dealer from dealing me cards over 21.

A friend uses her coins (quarters) on the friendlier slot machines and is rewarded with a shower of cash. At the window where the coins are exchanged for bills, she is given a moist towelette to clean her hands. The implication is surprising in an atmosphere so studied: Is money really dirty?

* * * * *

The legalization of casinos was supposed to cure all the urban ills of the dying Atlantic resort with no concurrent tradeoffs. According to *The Atlantic City Gamble*, "the early proposals for the casinos have an air of sweet youthfulness in retrospect."

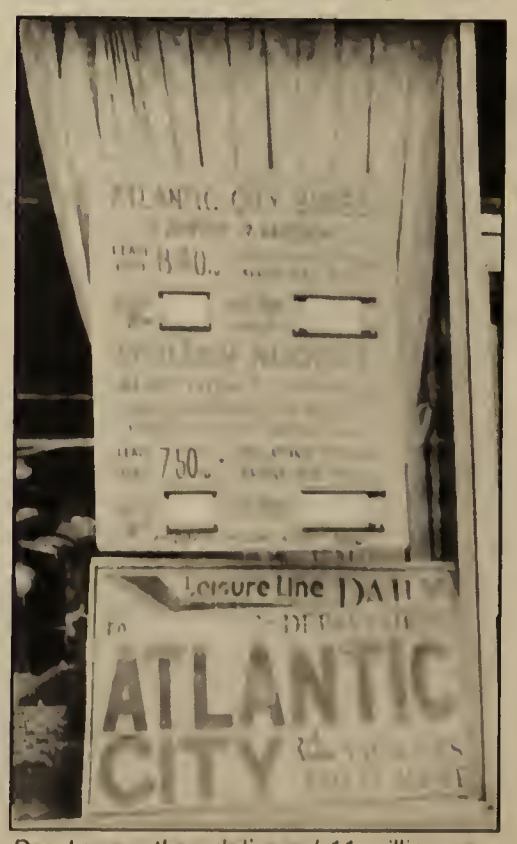
Originally, gambling there was to be more like that in Europe. There was to be no alcohol, and credit was to have been limited to cheques that would be deposited within two days of drawing. But this balance between casinos and control eroded as Atlantic City listened to the arguments of the casinos (at that time only the Resorts International) and feared other places would legalize gambling.

"The casinos got pretty much what they wanted," wrote Gigi Mahon in *The Company That Bought the Boardwalk*, (Random House, 1980), a chronicle of Resorts International, whose last section is titled "The Fall of New Jersey."

Alcohol was authorized and served free to high rollers (along with hotel rooms and entertainment). The casinos were essentially unregulated in their ability to extend credit, and, in fact, have credit offices right off the main gaming halls. The Casino Control Commission itself issued a waiver to eliminate "early surrender" in Blackjack, a way for gamblers to minimize their losses.

State attempts to regulate the casinos are now further complicated by the fact that 8% of gross revenues go to the state, constituting 2% of the total budget. Revenues from other forms of gambling add another 6%.

"Once a state has decided to legalize gambling, there is a self-generating tendency to expand when expected revenues do not materialize," wrote the authors of *The Atlantic City Gamble*.



Day buses: they delivered 11 million people in 1983

The state is still attempting to regulate the casinos. A bill has come out of committee to have a governor's advisory committee on gambling. Another bill would put a $25 tax on all machines, in the hope that such money would go for the treatment of compulsive gamblers. Still another would limit the amount of uncollectable debts the casinos would be allowed to write off on their taxes.

Are the regulators getting ahead of the regulated?

"There's no way to get ahead," said James Kullander, a legislative aide who has worked with Assemblyman Chuck Hardwick, perhaps the chief regulator. "Every time we come up with a new regulation, they find a way to get around it."

The effect of the casinos on Atlantic City remains mostly mixed, some would say mostly negative. While the casinos have definitely brought in people and money, and a total of 29,000 new jobs were created during the first four years, unemployment figures are about what they were before legalization. High casino wages lured nurses away from Atlantic City hospitals; high taxes and rents forced most small businesses off the boardwalk.

While the casinos now provide 60% of the tax base for the city, much of the taxes must now go for services necessitated by the casinos. The buses are creating traffic problems, the number of homeless people has increased way out of proportion to the increase in the rest of the state, churches are falling on hard times, and crime has increased.

While organized crime was a part of the city before legalization, a number of murders in the area have apparently been caused by fights over who will service the casinos.

What money the casinos give to the city or state often comes with strings attached. One casino, for example, offered to pay for the entire state share of a federally co-sponsored railroad from Philadelphia to Atlantic City — on the condition that the Casino Control Commission approve its plans for a casino hotel at the Atlantic City terminal of the proposed railroad.

* * * * *

While groups concerned with compulsive gamblers would like to see credit made tighter and alcohol outlawed in the casinos, their plan of action now is simply to get the casinos to devote some funds to the treatment of compulsive gambling, similar to funds given by distillers for the treatment of alcoholics.

Robert Klein, director of The Council on Compulsive Gambling of New Jersey, Inc, told **The Journal** the NJ state health department estimates that there are 375,000 compulsive gamblers in the state, with each gambler affecting from six to 12 other people. A survey of two correctional institutions in the state found that 25% to 30% of the prisoners were there for gambling problems.

So far, the only gambling revenue (from the lottery, not the casinos) in New Jersey going to compulsive gambling is a grant to study the disorder given to Dr Peter Carlton, a psychiatry professor at Rutgers Medical School, who has found differences in the electroencephalographs of compulsive gamblers that might signify slight differences in brain hemisphere dominance.

The state of New Jersey funds two treatments facilities, as well as educational efforts and a hotline 800-GAMBLING sponsored by the Council on Compulsive Gambling of New Jersey, Inc.

* * * * *

The bus ride back is quiet. If the passengers are typical, they will have each lost $20, making it worth the casinos' while to bus them, essentially at cost.

"We had a nice group of people this time," someone says. "Nobody got drunk."

Children of alcoholics honor Canadian

By Karin Maltby

ORLANDO — A Canadian social worker, hailed as a pioneer for her landmark research into the needs of children of alcoholics, has applauded United States efforts in this area.

However, Margaret Cork, MSW, author of the 1969 book, *The Forgotten Children*, is still waiting for the momentum to catch on in Canada.

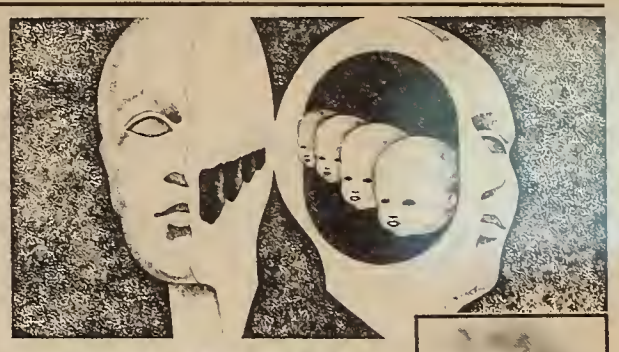
In February at the US convention here of the National Association for Children of Alcoholics (NACoA), Ms Cork's efforts were recognized again.

The NACoA has established The Margaret Cork Award to be given to others of merit in the years to come, who "demonstrate their compassion, commitment, and deep concern for children of alcoholics, through their scholarship, their innovative treatment approaches, or advocacy for and about children of alcoholics."

Ms Cork retired in the early 1970s as head of the Addiction Research Foundation (ARF) of Ontario's now-defunct Youth Counselling Service. It was from this department that she studied 110 children as the basis for her book. Her goal, she told **The Journal**, was that a 20-year, longitudinal study be undertaken to track these children as they grew into adulthood. But the study did not materialize.

Kathleen Michael, who worked with Ms Cork and is now a youth and family consultant for the ARF, accepted the award on her behalf.

She read a letter to the conference from Ms Cork: "My study was written, not out of my own deep concern and compassion for these children, but in the hope that since I was near the age of retirement, other caring individuals would follow after me . . . . I am deeply impressed with all that the NACoA has already achieved in its short history. I cannot help but wonder when it will spread to the Canadian scene when our problem is relatively as great as yours."



The Children Remembered — Pages C1-C4

Cork

Vol. 14 No. 4 2nd Class Mail Reg No. 2776 ALCOHOLISM AND DRUG ADDICTION RESEARCH FOUNDATION OF ONTARIO TORONTO April 1, 1985

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

International treaty targets traffickers' profits

Drug wars 'an issue of national security'

By Anne MacLennan

VIENNA — The need to halt illicit drug production and traffic has moved beyond being a moral defence or even a public health issue and is now one of national security for some countries.

This is the consensus of governments around the world, led by countries who say their political stability and public order is being threatened by illicit drugs traffic and production, and by "narco-terrorism," the funding of international terrorism of both the political left and right with profits from drug crimes.

Thus, with a push from one of the globe's drug and political hot spots, the 40 member-countries of the world's top, drug policy-making body have agreed unanimously that the war on drugs must be carried by all governments to a tough new level.

It will be a level where nations and the world community have the sophisticated legal weaponry to tackle the high-tech criminals who mastermind trafficking networks that span the globe and outstrip many, if not most countries, in terms of human, financial, and technological resources.

The consensus was reached by the 40 member-countries, and applauded by many observer countries, as the United Nations Commission on Narcotic Drugs closed its eight-day, 31st-session here in February.

Their particular target now is the illicit assets of drug crimes. "If we can remove the profit, we'll reduce the incentive." That's the rationale.

The proposed vehicle for arming nations and the international community is a new world treaty focusing on traffic and on the tracing, seizing, and forfeiture of the proceeds of drug crimes.

World war on drugs pages 7-8

It would see nations bolster and concentrate outdated or inefficient drug laws to meet the demands of a phenomenon that barely existed as recently as the early 1960s and early 1970s when the two main international drug control treaties came into effect.

And, it would bring the legal muscle of the world community to tracking drug criminals right through to their laundered-money bank accounts.

As international drug trafficking has escalated, so too have discussions about how to cope — in individual countries, in groups of countries, and in expert UN and non-UN committees.

A new treaty or convention has been seen as one promising approach. Others have felt that it is time to amalgamate the existing treaties into one, adding whatever is necessary to strengthen laws to get at drug profits.

Superintendent Rodney Stamler, chief of narcotics enforcement for the Royal Canadian Mounted Police has sat on two of the expert groups. (**The Journal**, February).

However, in the past year, Latin America, with support from several other countries, has made a strong appeal directly to the United Nations General Assembly (GA) in New York for a new treaty, and a new treaty now.

And, from its autumn 1984 meeting, the GA, through its own hierarchy, directed an order to the Commission: "As a matter of priority . . . initiate the preparation of a draft convention against the illicit traffic . . . at the February session."

One of the leading voices from the Latin group has been Venezue-

(See — Treaty — page 2)

Cocaine is more than a police problem

By Harvey McConnell

WASHINGTON — Cocaine must be seen and treated as a global community health problem and not just a law enforcement problem, believes Carlton Turner, PhD, director of the White House Office on Drug Abuse Policy in the United States.

Cocaine and other drug abuse "is a world-wide community problem which involves every facet of the community. It is a health problem and there is no way to get around that," Dr Turner told **The Journal**.

"For years we treated it as a law enforcement problem, and all that did was to allow people to blame the police for not solving their problems. If we treat it as a law enforcement problem, we are doomed.

"But, until the world community decides it is not going to tolerate drugs anymore, there is going to be a drug problem worldwide."

Dr Turner notes that in the US "we didn't get into this situation overnight: in 1973-74, we knew that cocaine was coming and we knew about the addictive potential of cocaine."

At that time, Dr Turner and colleagues at the University of Mississippi received a grant to study the reinforcing potential of cocaine, and, in 1977, he started importing coca leaves to investigate coca paste. Yet, it was tough to get people in the substance abuse field interested in the potential problems.

Dr Turner believes it will take time. "But, we can come out of this cocaine crisis if we don't wring our hands and say we can't do anything. We didn't get into this situation here and abroad overnight, we knew the potential 10 years ago.

"Now we have a major treatment problem, and some people say the sky is falling in. That's exactly the attitude which will insure the sky will fall in."

Turner: the sky is falling

Bureaucrats and officials in many countries will have to face the fact drug abuse does exist in their countries. "Once you get people facing up to the fact that drugs are a big part of society, and they quit denying the facts, then you can start to get something done."

Dr Turner says that despite the glaring evidence of what havoc cocaine can produce, some people still want to talk about the "good side" and the "bad side" of drug abuse.

"We have never before had a health problem in which we have to talk about the 'good side' and the 'bad side.' You don't hear people talking about the 'good side' of AIDS (Acquired Immune Deficiency Syndrome) do you?

"It bothers me that some people have a problem using the word 'addiction' to anything except heroin. If you take a soft-language approach to try to make drug use go away, then you are just going to dig yourself in deeper."

A major need is to keep up prevention efforts among young people, he said.

Emergency room episodes involving cocaine are up, but studies have shown a lag time of up to five years from first use to addiction. No one disputes that marijuana use is dropping, but emergency room episodes for it are going up as well, because there is much more potent marijuana available.

"We have got a group of people in our society who are heavy drug users," Dr Turner adds. This does not mean that the overall number of people using is not going down; the annual US household survey and other surveys indicate this.

As for the threats of death to and kidnapping of US officials by cocaine traffickers (**The Journal**, March), Dr Turner said this may be a reaction to the fact that more and more pressure is being applied to the traffickers.

Meanwhile, the US House of Representatives foreign affairs committee, which is under Democratic Party control, has called for a Pan-American, anti-drug police agency. The report wants the US Central Intelligence Agency brought in for spying and intelligence tasks.

The report proposes that the Pan-American police force receive supplies and technical assistance

(See — International — page 2)

Healthy Youth Our Best Resource

World Health Day, April 7, will concentrate attention on youth, who, says Dr Halfdan Mahler, director-general of the World Health Organization, have a large role to play in health care. "In 1985, International Youth Year, the world will harvest not only its biggest but also perhaps its best crop of young people in history."

INSIDE

NEWS

Briefly...

Clove oil cigarettes

EDMONTON — Canadian youth may be exposed to new smoking hazards as Indonesian cigarettes flavored with oil of clove gain popularity among teenagers. Tee Guidotti, of the University of Alberta, department of occupational medicine here, warns that some additives in clove oil may be dangerous. These dangers are added to the hazard to lungs from tar and nicotine in the the harsh tobacco used. Clove cigarettes became popular among California surfers in 1980 and sales have risen to $100 million a year in the United States. Dr Guidotti told *The Globe and Mail* the fad has now spread to Canada where the cigarettes are available through department and variety stores.

Anxiety on the brain

WASHINGTON — An "anxiety chemical" found in human brains has been isolated by researchers at the United States National Institutes of Health. The chemical, a complicated protein, causes anxiety and reverses the effects of such drugs as Valium (diazepam) and Librium (chlordiazepoxide), says *The London Sunday Times*. Researchers think the discovery may lead to better anti-anxiety drugs.

Mexican alcoholism

MEXICO CITY — Alcoholism among Mexican women has reportedly doubled in the 10 years between 1970 and 1980, says a report in *The Medical Post*. A study by the Institute for Orientation and Defense of Women here, says alcoholism among women increased to one in five in 1980 from one in 10 in 1970. And, the group believes the ratio has been increasing since 1980. The new General Health Law which attacks the problem of alcoholism in Mexico, may arrest the trend and reverse it, the Institute says.

Medication hot line

WINNIPEG — Helping elderly patients better understand their medicines is the aim of a hot line established here by the University of Manitoba faculty of pharmacy. Believed to be the first in Canada, the Medication Information Line for the Elderly also provides patients an opportunity to ask questions they did not ask their pharmacist or doctor. Information is also available to health professionals caring for the elderly, reports *The Medical Post*.

Alcohol and the pill

NORMAN, Oklahoma — Women taking oral contraceptives should be cautioned about possible interactions of the pills with ethanol, report researchers from the University of Oklahoma, here. A study of 40 women showed that the 20 who were taking birth control pills had a significantly decreased rate of ethanol metabolism compared to 20 controls who were not taking the pill. The results were consistent throughout the menstrual cycle, reports the Alcohol Awareness Service of the United States National Institute of Alcohol Abuse and Alcoholism.

Low-cost assessment methods are needed

World drug use stats in poor shape

By Anne MacLennan

VIENNA — There are still large holes in the global picture of drug abuse, says Tamar Oppenheimer, director of the United Nations Division of Narcotic Drugs here.

She said that seizure, arrest, and other statistics available on illicit traffic are "seldom complete, frequently tardy, and contain their share of anomalies and apparent contradictions.

"Nevertheless, they are very much more complete than available data in respect of the nature and extent of drug abuse," she told the opening session here of the 31st UN Commission on Narcotic Drugs.

She said the problem is that many states are still unable to measure accurately and inexpensively the extent and nature of drug abuse, and, therefore, to provide reliable and comparable data for analysis.

"Without these baseline statistics, it will continue to be difficult to assess in real terms the extent of the problem, to determine what range of remedial measures should be applied, and, most important, to evaluate the effectiveness of measures that have been put into effect."

She suggested that in order to achieve success, the Commission should consider reinforcing its requests to governments to direct more attention to prevention and reduction of demand for drugs.

"This might usefully include greater concentration, possibly with international support, on identifying and developing low cost methods of assessing the extent of drug abuse, so as to identify major targets and to apply countermeasures which have been proved to be successful."

Mrs Oppenheimer, also deputy to the director-general of the UN office at Vienna, is in her third year as director of the division.

Oppenheimer: contradictions

Treaty needed to protect Latin governments

(from page 1)

la's. A politically-stable country, and a democracy, it is situated perilously close to the world's largest cocaine producing and trafficking countries — Colombia, Bolivia, and Peru. Despite dwindling wealth in the wake of an oil honeymoon and decreasing world prices for oil, it is also a haven of relative political quiet, in a Central and South American sea of political turmoil.

Elsa Boccheciampe Crovati, minister counsellor to the Venezuelan Mission in New York, was a member of the Venezuelan delegation to the Commission. She put the case for the treaty and the treaty now, to **The Journal**:

"In the last 15 years, illicit drug traffic has escalated to such a magnitude that . . . it has developed into the most formidable enemy against health . . . and a menace to legitimate governments.

"The enormous ways and means of drug traffickers have become allied to subversive tendencies of the left and right, which threaten the survival of democracy. That's the way we feel, and I'm quoting the president (Jaime Lusinchi).

"Our economies, our population, and our way of life are threatened."

She said while countries less apparently or immediately vulnerable "are daunted" by the haste with which the Latins are pursuing a treaty, "other regions must realize that, as in everything, in drug trafficking, timing differs.

"Our needs are now, in the short term. And the short term should be favored.

"If the critical short-term needs of some regions are not met, it could represent a danger to some of those countries that think now that their needs are longer term," she said.

But, a decision "to initiate preparation of a draft convention" does not a convention make. For now, countries are examining the problems, some of the suggested solutions, including those of the various expert committees, and considering comments and proposals they would like to have incorporated in such a draft convention.

They'll come together next February at a session of the Commission called especially for discussion of this item. A treaty could be two or even three years or more away.

Nonetheless, some observers believe that the consensus alone represents a kind of progress — and that, while the combatants are not yet equally armed, the community of nations has now at least zeroed in on the next battlefield in the ongoing war.

Cocaine 'families' eyeing European markets

By Thomas Land

GENEVA — A group of Colombian crime "families" who control the saturated cocaine market of the United States are aggressively expanding their operations into Canada and Western Europe.

The United Nations World Health Organization (WHO) says cocaine abuse has reached "epidemic levels" in the Americas, and it is spreading rapidly in Europe. A group of experts brought together by the WHO has called on governments to give the "highest priority" to combating the health problems arising from "spiralling cocaine abuse."

Six Colombian families control much of the $80 billion global cocaine traffic. During the past two years, they have inundated the lucrative US markets with the drug. As a result, street prices are falling and the gangs must establish major, fresh sales outlets. Hence, the vigorous current expansion of their smuggling operations north of the Canadian border and across the Atlantic.

The smuggling rings, which are held responsible for the recent murder of Colombian Justice Minister Rodrigo Lara Bonilla, were able to establish themselves, over time, in the US because cocaine had been considered a "safe" drug.

"Now, more than one million US citizens are in need of professional help with their cocaine problems," says Francis Mullen, director of the US Drug Enforcement Agency (**The Journal**, March). Mr Mullen visited Europe recently to warn colleagues against concentrating efforts and resources in the fight against heroin while ignoring the risks from cocaine.

WHO experts in Geneva describe cocaine as "the most dependence-producing available drug" on the black markets. They consider that the rapid spread of cocaine addiction has emerged as a major threat to public health. They have urged the UN system to develop a common strategy and action plan to treat the health problems arising from cocaine abuse, and to seek measures to prevent the continued spread of the illegal trade.

Interpol in Paris believes that at least 30 tons of cocaine was smuggled into Europe last year, largely through Madrid and Frankfurt, at a street value of $4.5 billion, three times more than in 1983. And the UN's International Narcotic Control Board (INCB) in Vienna said earlier: "Seizures have risen sharply . . . showing that cocaine has become a major drug of abuse and that trafficking has gained a firm foothold in Western Europe. Most of the seizures were made in airports or in international trains en route from an airport to a country of consumption."

The INCB says cocaine has also become the second most popular drug of abuse (after cannabis) across Canada. Cocaine enters Canada by air or sea via Montreal, Toronto, Vancouver, or across the country's more than 6,000 kilometre border with the US. The first Canadian laboratory for the conversion of coca paste into cocaine hydrochloride was recently discovered following a big drug seizure in Montreal.

Several clandestine cocaine conversion laboratories have been discovered also in the US, particularly in the Miami area.

WHO experts say that the smoking of coca paste by urban youth in the producing countries of Latin America has also emerged as a widespread and dangerous phenomenon (**The Journal**, May 1984). Colombia, Bolivia, and Peru, the dominant producers, are all committed to various internationally supported programs to reduce or eliminate cultivation; and Colombia's widening war against the drug trade recently led to a world record seizure of 10 tons of cocaine and coca paste as well as 14 conversion laboratories and chemicals, weapons, and aircraft.

INCB Report — see pages 7-8

Int'l cooperation mandatory

(from page 1)

from the US with the manpower supplied by countries in the region. This would remove the US from the role of police officer, while allowing the countries to come to grips with their own problems.

"The solution to the problems can only come through international cooperation," says Lee Dogoloff, Dr Turner's predecessor in the White House under then-president Jimmy Carter. He is now executive director of the American Council for Drug Education here.

In Latin America, he told **The Journal**, "it is not that they are concerned about what goes up some fool's nose on Wall Street — they couldn't care less about that — it is a basic issue of national security." His worry is that some countries "may be too far behind the power curve now to do something."

The stakes are high, "and we are talking not only about political survival but also the younger generation and addiction to cocaine." Mr Dogoloff adds: "The technology exists. The question is whether the international will and determination can exist to deal with it."

Some drugs of abuse will never be eliminated, so the concern is prevention and education, and it appears the best targets — where a real difference can be made — are children at primary school level.

NEWS

Probe uncovers double-doctoring in Nova Scotia

By Betsy Chambers

HALIFAX — Tracking down and charging narcotic addicts who feed their habits with prescription drugs can be "a piece of cake," compared with the difficulty of stopping some doctors who supply them, Royal Canadian Mounted Police (RCMP) investigators discovered here, during a recent 18-month double-doctoring probe.

"The poor patients are persecuted really, but the doctors are still sitting there giving (narcotic prescriptions) to them," said RCMP Constable Kevin McNeil, the probe's chief investigator.

Under existing law, there is little he can do to stop doctors who insist on prescribing narcotics to known abusers. His only option is to report the doctors' names to the provincial medical board (PMB), the disciplinary body of the medical profession.

In Nova Scotia, "nobody has lost his licence for it, because nobody has ever unduly abused (prescribing privileges), knowingly," M. R. Macdonald, MD, chief of the Nova Scotia PMB said.

Marvin Burke, executive director of the Nova Scotia Commission on Drug Dependency is not prepared to be complacent about the situation.

"Well you can do something about it," he said. "Number one, the body responsible has to take action — that's the provincial medical board, and it has to take appropriate action."

With skyrocketing health care costs and limited revenues, the economic impact of double-doctoring on the province's health insurance scheme, Medical Services Insurance (MSI), is worrisome.

Doctors bill MSI for both seeing patients and prescribing drugs. If the patients happen to be narcotics abusers, the department of health eventually foots the bill for their rehabilitation through the commission while the department of justice pays to prosecute them.

Health Minister Gerald Sheehy has said if he cannot be assured that doctors are policing themselves by cutting out the practice of prescribing narcotics to known abusers, then he will take the issue up with his colleagues at the next Canadian health ministers conference.

The furor has sprung up as the result of preliminary findings of an RCMP probe which trailed 14 drug abusers here, whose names were supplied by the Bureau of Dangerous Drugs in Ottawa.

The RCMP found the 14 received narcotic prescriptions from 146 general practitioners, almost all of them in the Halifax-Dartmouth area. Thirty-five of them had handed out more than 1,100 narcotic prescriptions to the abusers between January 1, 1983 and June 30, 1984, and were watched closely by police.

Of that group, 18 doctors were discovered to be handing out most of the prescriptions, which are now believed by police to be nearer the 2,000 mark, and three other doctors were found to be filling out narcotic drug orders every third or fifth day.

While 105 charges have been laid so far against the 14 abusers, no police action has been taken against any of the doctors alleged to have been most involved.

Under the Narcotics Control Regulations, only patients can be prosecuted for double-doctoring. Anyone acquiring a narcotic prescription within 30 days of a visit to another doctor is required to divulge that information to the physician. Failure to do so can lead to charges of double-doctoring and penalties on conviction, ranging from a $50 fine to a jail term.

Although the probe only followed 14 abusers, the Bureau of Dangerous Drugs Director, Jacques LeCavalier, confirms there are between 135 and 140 known abusers in the province.

"The numbers . . . that doesn't surprise me," Mr LeCavalier told **The Journal**, referring to the statistics uncovered in the Halifax probe. "It's certainly not the worst case we've seen. I recall one case in Ontario, in 1982, where five individuals succeeded in consulting 300 doctors and got their 'scripts filled in 1,100 pharmacies."

During the 18-month investigation in Halifax, Mr Burke estimates more than a quarter of a million dollars worth of legally-prescribed narcotics were on the streets.

No one knows if the drugs were being sold, but Mr Burke is convinced they were. "I don't believe that anyone of these people is using all of the drugs prescribed . . . it's too much."

Constable McNeil said he found some doctors prescribing Percocet (oxycodone) in quantities as high as 100 tablets, while Dilaudid (hydromorphone) was being authorized in amounts of up to 50 or 60, 4 milligram tablets, and Tussionex (hydrocodone and phenyltoloxamine) was sometimes ordered in amounts of 200 to 240 millilitres.

Constable McNeil said within the first 10 months of the probe, he spoke to nearly all the 35 doctors pinpointed for close scrutiny in the investigation, and told them that double-doctoring was taking place.

The Medical Society of Nova Scotia is no less concerned about seeing the PMB take action. "We support the RCMP and the PMB entirely, and the prosecuting of doctors who have been shown to be trafficking," said Merv Shaw, the society president.

"Those doctors who have been abusing their prescription privileges should definitely be reprimanded, or their licence removed, or whatever is necessary to curb the problem," Dr Shaw said.

The double-doctoring probe has put pressure on the commission for treatment and resources.

Narcotic drug abusers are "a lot harder to deal with" than the standard fare of alcoholics the commission usually treats. Facilities are limited. Mr Burke: "I could take in one or two in-patients, but if you give me 10, I've got a problem," he said.

The commission can handle drug addicts but not large numbers, and mainly on an out-patient basis.

As a result of the probe, Mr Burke said, the courts have been sending the convicted double-doctorers to the commission for treatment as a condition of their probation orders.

Meanwhile, the doctors who were found by the RCMP to have written 10 or more narcotic prescriptions to the abusers in the probe, "were all written letters by the PMB asking for their justification in issuing these prescriptions," said Dr Macdonald.

"As of today, they have all replied. And so these responses and the prescriptions — the originals — will be considered at an early meeting of our disciplinary committee, at which time some action will be taken," he said.

Getting doctors to stop isn't easy

By Betsy Chambers

HALIFAX — Getting doctors to stop legally prescribing narcotics to an estimated 3,000 to 4,000 drug abusers in Canada is "not an easy, black-and-white issue," Jacques LeCavalier, director of Ottawa's Bureau of Dangerous Drugs, Health and Welfare, says.

The names of suspected drug abusers cannot be circulated to physicians. Only upon conviction can the names be made public. To do otherwise, legal experts contend, would contravene the provisions of the Privacy Act and the Charter of Rights and Freedoms.

People with similar names might be stopped from obtaining legitimate medical treatment, or the suspects might turn out to be innocent, said Mr LeCavalier.

Doctors who continue prescribing to addicts fall into three categories, Mr LeCavalier said.

"One would be a small minority of practitioners who are outright dishonest, who will actually sell 'scripts or drugs themselves, or will exchange them for other considerations.

LeCavalier: a small minority

"Then, there is the physician who may be complacent about the situation and will repeatedly prescribe drugs for individuals who solicit them.

"And there is a third category within that small group of physicians who are well-meaning but feel the way to solve the problem is simply to prescribe the drug to the addict."

Mr LeCavalier said the bureau, which monitors narcotics dispensing, launches an investigation when it finds a doctor may be involved in feeding an addict's habit. The doctor is asked to explain why the narcotic was authorized.

"When we find that (the response) is not acceptable, it's referred to the provincial licensing authority in the first instance," he said.

If the same doctor repeats the practice after the referral, "we have the ability to withdraw the prescribing privileges."

The action is taken in concert with the medical boards and the names of the chastised doctors are never made public.

"The notification process is limited to narcotics and controlled drugs, and it's not intended to influence the physician's ability to practice medicine."

Making the names of notified physicians public "could tarnish the physician's reputation and affect his overall practice," he said.

Maestro's cruel critics missing the beat

By Wayne Howell

To the Audio-Visual Assessment Group
Addiction Research Foundation

I realize that you assess up to 50 audio-visual presentations per year, and only some can be rated and featured in the Projections section of **The Journal**. But with regard to my recent submission entitled *Addictions Symphony*, hey, a "general evaluation" of 0.0 is a little hard to take, as is the accompanying comment, "cacophonous nonsense devoid of any instructional or educative value." But hey, did Verdi and Bizet give up writing operas because *La Traviata* and *Carmen* premiered to 0.5 ratings? Did Stravinski take up a position in the post office after they booed *The Rite of Spring* off a Paris stage?

The great ones soldier on, despite the carpings of critics. And speaking of the carping of critics, I'm going to answer your questions about *Addictions Symphony* point by point:

1) *What in God's name is it anyway?* This question only betrays your ignorance of new developments in audio-visual techniques. I refer you to the March 5, 1985 issue of *The Globe and Mail*, in which science writer Stephen Strauss explains how researchers Steven Frysinger and Joseph Mezrich are using computer-generated sound to express statistical relationships. Strauss describes how they have generated computer sounds to simulate economic activity — a trumpet for car sales, a bassoon for housing starts, and so on.

They have discovered that an economic depression doesn't sound like the crying of hungry babes or the silence of factories, it has an "ooooh sound, like a power plug has been pulled or like you are listening to music and all of a sudden someone pushes their thumb on the record." Frysinger and Mezrich are working on tracking stock-market trends and DNA sequences in a similar manner. Although they admit "audial data representation" has some "intrinsic problems" (hey, maybe somebody once gave them a 0.0 rating too) they see a great future in it, especially since the cheapness and availability of sound-synthesizing computers mean that "sound data's problems are now open to resolution by tens of thousands of home hackers." So to answer the question — what is it anyway? *Addictions Symphony* is a four movement sound-graph of drug-abuse statistics covering the last 20 years.

2) *What do these sounds mean?* Well hey, I admit my documentation failed a little in this regard; perhaps I erred in thinking your aesthetics would be similar to mine. In any event, for the record, the tenor sax sound represents marijuana use. The Pan-flute sound represents the use of psychedelics. Heroin is the sensuous violin, alcohol is the insistent double-bass, and cocaine is the trumpet.

Why these instruments, you ask? They just felt right. Well hey, they make more sense to me than using a bassoon for housing starts. And as for the light orchestration, well hey, an artist is limited by the medium in which he works — is it J. S. Bach's fault he never had a piano? Is it my fault my computer only cost $99?

3) *Why does it sound so awful?* Well for starters, the frequencies of drug use do not correspond to the frequencies we associate with the chromatic scale. (In this regard, please refer to *The Globe* article: Frysinger and Mezrich almost always get dissonant chords when they program the economy.) But notwithstanding that, I do not think the *Addictions Symphony* sounds as "awful" as you say it does. Is there not a nice little flute solo in the first movement (65-70)? And is there not a bang-up Maynard Ferguson/Cottie Williams trumpet finale in the last movement (80-85)?

I admit that the second movement (70-75) and the third movement (75-80) can be a little confusing — the music tends to wander off in all directions — but hey, those double-basses, they never let up do they! Remember what Hector Berlioz said about the double-basses in the third movement of Beethoven's Fifth Symphony — how they sounded "like the gamboling of elephants?" Well in *Addictions Symphony* they gambol from beginning to end.

4) *What, in God's name, is the point?* I refer you again to the article in *The Globe:* "While promising, audial data must overcome some intrinsic problems . . . researchers also feel they need a breakthrough use — identifying earthquakes or DNA — to incite market interest." Hey, *Addictions Symphony* is a breakthrough use. Listen to it again. Note the progression of tempi — from andante to allegro; note the lack of diminuendo, the frequent crescendi; note the trumpet in the final movement — it's not playing *Taps* that's for sure. And if the dissonance bothers you well, hey, I've got another computer-generated tape called "Institutional Responses to Drug-Abuse Problems 1965-85" that makes this tape sound like a Haydn string quartet.

Yours truly,
A Home Hacker

NEWS

RESEARCH UPDATE

Addiction progression in solvent abusers

The common belief among addiction workers that glue sniffing is a transient problem that does not continue into adulthood is wrong, say three British researchers. Brenda Davies, Anthony Thornley, and Denis O'Connor of Newcastle-on-Tyne evaluated a group of solvent abusers who progressed to using illicit drugs including heroin. They concentrated on four patients who misused solvents for an average of 4½ years and then started abusing drugs such as LSD and heroin. When evaluated, the ages of the patients ranged from 18 to 23 years. While the transition from glue sniffing to the misuse of other substances could not be clearly explained, the researchers said, all the patients were living in a state of "chronic stress" as a result of individual problems and basic insecurity. All of the group had suffered parental deprivation or rejection, or both, and there was a history of physical abuse in three, the researchers said. They hope to determine the characteristics of the minority of young adults who progress from abusing solvents to other addictions in a rigorous follow-up study.

British Medical Journal, Jan 12, 1985, v.290:109-110

Severity of artery disease linked to smoking

The number of cigarettes smoked in one's life may correlate with the severity of coronary artery disease that may develop. That is the conclusion of a large British prospective study which examined the association between smoking and the severity of coronary artery disease in patients undergoing routine coronary arteriography prior to valve replacement surgery. Researchers in the regional cardiac unit of Wythenshawe Hospital, Manchester, evaluated 387 patients, 229 of whom were current or former smokers, who underwent routine arteriography at the hospital in 1980. They found the total number of cigarettes smoked correlated significantly with the severity of coronary artery disease and the number of coronary arteries with stenoses of 50% or more. The severity of the disease was found to be similar in current smokers and former smokers who had stopped for at least one year. Multiple regression analysis showed that a number of other factors such as age and history of angina were also important predictors of the severity of coronary artery disease and, for that reason, the researchers said the complex interaction between smoking and these factors makes it difficult to assess the importance of smoking as an independent risk factor. But taken in conjunction with these factors, they concluded the number of cigarettes smoked in life "can be useful for identifying patients with coronary artery disease."

British Medical Journal, Jan 19, 1985, v. 290:197-200

Drug abuse attitudes tested

An effective questionnaire has been developed to assess medical student and physician attitudes toward alcohol and other drug misuse. The Substance Abuse Attitude Survey (SAAS) was developed in the departments of psychiatry and behavioral sciences, University of Nevada School of Medicine, Reno. It was developed because of the perception that health professionals with negative attitudes toward such abuse do not bother to learn much about abuse problems and are reluctant to apply what they do know. Through repeated applications of a number of variations of a questionnaire given to clinicians who specialize in the treatment of substance abuse, and other doctors, the three researchers were able to develop a scale based on five factors which form the SAAS. These factors are permissiveness, treatment intervention, non-stereotypes, treatment optimism, and non-moralism. The 50-item test has been applied to, and readily accepted by, both medical school students and participants in continuing medical education programs in four states in the United States, during a five-year period. Evaluation of the test shows that clinicians involved in abuse treatment score significantly higher on the treatment optimism and treatment intervention elements of the SAAS than other clinicians. Changes in attitudes of medical students following different educational experiences in the area of substance abuse can be measured with the SAAS.

Journal of Studies on Alcohol, Jan 1985, v.46:48-52

Alcohol and burglary

Researchers should not automatically assume that alcohol is more commonly involved in crimes of violence than in property crime, a British study has cautioned. Trevor Bennett and Richard Wright of the Institute of Criminology, University of Cambridge, examined the use of alcohol in relation to breaking and entering (burglary) by interviewing 121 offenders currently serving sentences for residential and non-residential break and enter offences. Asked about their usual drinking habits immediately prior to undertaking break-ins during their last period of offending, 65.3% of the subjects admitted consuming alcohol prior to at least some of their break-ins, and approximately one-third said that most of their offences were committed under the influence of alcohol. The study also found a strong correlation between patterns of pre-offence drinking and normal drinking behavior. Most of the offenders saw no causal relation between their alcohol use and their criminal activity, the researchers said. Subjects argued that either their offences were planned in drinking situations, independent of the effect of the alcohol consumed, or they drank frequently anyway and saw no reason to change normal drinking patterns simply because they intended to commit a crime. Given the study findings, the researchers concluded "the exclusion of the study of crimes against property on the grounds that alcohol use is more commonly involved in crimes against the person is surely unwarranted."

British Journal of Addiction, Dec 1984, v.79:431-437

Pat Rich

'Fortunes are spent' to keep women smoking

Cig industry gets direct hit

TORONTO — Cigarette smoking is a feminist issue, and women need to be reminded periodically, says the dean of nursing for Queen's University, Kingston, Ontario.

As part of her keynote address to the Ontario Advisory Council on Women's Issues conference on women and health here, Alice Baumgart, PhD, took direct aim at the tobacco industry.

"When one leaves aside the escalation of defence spending, one of the most vigorous members of the pro-death lobby is, of course, the tobacco industry," she said.

She noted that despite a marginal turnaround in statistics in the last year in Canada, females continue to be North America's fastest growing group of smokers, and the current lung cancer epidemic among women is almost totally attributable to smoking.

Looking at women's magazines as purveyors of messages about the appropriate role and aspirations of women, Dr Baumgart said there is "ample evidence of how the tobacco industry spends a fortune each year to maintain high levels of smoking among women and really forestalls any feminist opposition."

She said it has been noted there is a virtual silence about the issue in feminist circles.

"In the constrained economic environment, surely this is one issue on which women can get together and help reduce the health risks to which women continuously succumb."

US alcohol treatment in jeopardy

By Lynn Payer

NEW YORK CITY — The prospective payments system now being implemented in the United States for Medicare payments is "potentially disastrous for alcoholism."

Leonard Saxe, PhD, associate director of the Center for Applied Social Science at Boston University, told **The Journal** the system, known as diagnosis-related groups (DRGs), pays hospitals according to the diagnosis, and not for the number of acts or the length of stay.

"My concern about DRGs and alcoholism is that DRGs are insensitive to the way alcoholism and alcohol-related disease manifests itself," Dr Saxe said, following a meeting on alcoholism here sponsored by Grantmakers in Health.

Dr Saxe said that the switch to reimbursement based on DRGs is the largest change in medical economics in the United States since the institution of Medicare in the 1960s. DRGs are currently in effect for Medicare patients (over age 65) in hospital, and are expected to be extended to Medicare out-patients. It is expected also that many private insurers will adopt the system.

DRGs are believed to have the potential for reducing unnecessary treatment. But, unlike another scheme of prospective payments, health maintenance organizations that are based on capitation, (DRGs) are organized around the treatment of one episode of one disease. Therefore, while health maintenance organizations are not likely to skimp on treatment if it will result in later complications or other diseases, the incentives of the DRGs will be to treat one episode of one disease as economically as possible. This presents several problems for the alcoholic, Dr Saxe said.

While people who do receive treatment for alcoholism in the US are probably overtreated, the disease as a whole is undertreated. Dr Saxe is the author of a report for the Office of Technology Assessment, which concluded that while few randomized, controlled clinical trials have shown which treatments for alcoholism are effective, in general any form of treatment seems to be better than no treatment. The report strongly urged that out-patient treatment be encouraged as opposed to the more expensive in-patient treatment.

• Alcoholism requires treatments most frequently with co-morbid conditions, and the co-morbid diagnoses such as liver disease may result in greater payments to hospitals than the diagnosis of alcoholism.

• While guidelines do exist to prevent gross undertreatment of disease, they are better adapted to diseases other than alcoholism. Patients readmitted to the hospital within six months of their treatment with the same disease, for example, would have to be treated under the same payment. This would discourage "treating appendicitis with a Bandaid." But "alcoholics will be able to stay out on the street without the necessity of readmission," even though their disease has not been cured.

• The fact that payments for DRGs are based on the average length of stay has already created problems for treating alcoholism. "The average length of rehab might be fine for a surburban hospital, since the best predictor of success is social stability," but the same length might be grossly inadequate for inner-city patients.

Dr Saxe added that DRG-based payments for alcoholism have been temporarily suspended until October 1, 1985 in an attempt to work out some of the problems.

Saxe: potentially disastrous

New York City's homeless burdened by addictions

By Lynn Payer

NEW YORK CITY — Sixty-six percent of the homeless population here have been previously enrolled in drug treatment programs, one quarter are regular users of hard drugs, at least one-third currently abuse alcohol on a regular basis. And a study released by Senator Frank Padavan, chairman of the New York State Senate Committee on Mental Hygiene and Addiction Control has found 35% of the homeless are mentally disabled.

The report called the homeless population, which numbers between 40,000 and 60,000 individuals here, "a direct consequence of New York State's failed mental hygiene and social services policies."

When the state mental health system began to deinstitutionalize several years ago, says the report, "New York concentrated nearly all of its efforts on identifying the discharging individuals." In the area of follow-up care and support services, according to the report, the system failed.

Economic factors such as unemployment and lack of low-income housing have exacerbated the problem, says the report, but Senator Padavan disagreed with State Governor Mario Cuomo, who called today's homelessness a problem of poverty, not pathology.

In disagreement with Gov Cuomo, the report says the homeless mentally ill and substance abusers primarily need treatment. Recent efforts to relieve the plight of the homeless, however, have concentrated on housing initiatives and temporary shelters.

The report points out that the State of New York now has the capacity to provide alcoholism treatment services to approximately 1,215 individuals per year. "It can be estimated that 13,200 individuals within the homeless population alone require some type of intensive alcoholism treatment."

As for drug abusers, the report points out, New York State drug treatment programs during the 1983-84 fiscal year operated at 99% capacity and, at most facilities, individuals were put on waiting lists before being admitted. There is only one residential program specifically targeted to homeless individuals.

"With the demand for substance abuse services at an all-time high, the homeless individual in need of these services is the least likely to receive them," the report concludes.

Psilocybin use mushrooms among young experimenters

LOS ANGELES — Traditional drug use surveys may be missing a trend to increasing psilocybin "magic mushroom" use among young people.

Researchers at the University of California (UCLA) department of psychology, here, say psilocybin use may be under-reported in surveys which query LSD or other hallucinogen use, without specifically mentioning mushrooms.

"People who take mushrooms may not be answering questions on psychoactive drug use, because they do not equate mushrooms with LSD the way researchers do," Douglas Anglin, PhD, and colleagues say.

A survey of 1,507 college students at UCLA and California State University, Northridge, showed that mushrooms are now the most widely used hallucinogenic drug (14.8% of the total survey population reported lifetime use).

More striking, the researchers say, is that more than one-half of the reported hallucinogen users only use mushrooms.

But, the study shows extended use is uncommon, suggesting that "psilocybin use is experimental in nature and that use by the general public is a recent phenomenon."

Hallucinogen use declined between 1975 and 1979, United States national surveys report. This was followed by a stabilization or slight increase since 1980, a trend the researchers say may be attributed to increased use of psilocybin.

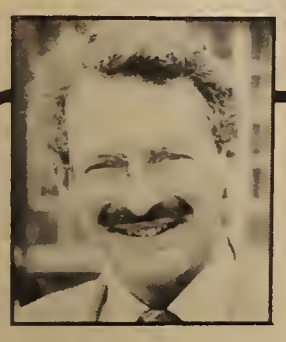
One-third of the students surveyed said they had noted increased use recently. However, only 10% of the total sample had used mushrooms 10 times or more.

"The low frequency and few negative effects (reported by students) indicate that abuse is not a problem, nor is there evidence for predicting development of a problem," the researchers noted. However, they recommend better monitoring of the drug through revised questions on surveys to separate psilocybin from other hallucinogens, and through studies of behavioral aspects of the user population.

In the California study, two important characteristics distinguished users of mushrooms from non-users. Mushroom users were more apt to use other drugs, expecially marijuana, cocaine, and alcohol. And, age of first use for these three other drugs was approximately one year earlier than for non-users.

"Overall, these results suggest that mushroom users may be more inclined to risk-taking and sensation-seeking behavior," the researchers report. "These results are not unlike those found for users of marijuana in studies conducted prior to 1975."

Psilocybin



GILBERT

'. . . an amphetamine-like plant material'

Khat: history, chemistry, pharmacology

First of two parts

By Richard Gilbert

Khat is also known as kat, qaad, qat, and q'at in the medical literature. These words and many others — chat, gat, jaad, mira, miurungi, ol-meraa, tomayot, tschat, etc — refer to a shrub resembling a small, white poplar tree. The plant's botanical name is *Catha edulis*. It is found, cultivated, and used in the humid mountainous regions of eastern Africa, from Egypt to South Africa including Madagascar, and also in the Arabian peninsula and as far east and north as Afghanistan. More particularly, khat and the other words are names given to the leaves and young shoots of the plant.

Khat is used — generally chewed — for its psychoactive effects. According to a recent World Health Organization (WHO) report: "The syndrome observed after khat consumption is characterized by a certain degree of central nervous system stimulation and by sympathomimetic effects; it is reminiscent of that induced by amphetamine. . . . Cultivation and consumption of khat have profound socioeconomic consequences for the countries concerned and the use of khat has considerable impact on the life of the individual. Khat chewers are mostly male and the harm to their families is due to negligence, dissipation of family income, and inappropriate behavior."

In 1980, the WHO classified khat as a drug of abuse that can produce mild to moderate psychic dependence but little, if any, physical dependence and tolerance.

History

I first became interested in khat when I read in an article in **The Journal** in 1977, that khat contains caffeine. Subsequently, I found this is not so, even though early investigators suspected its presence. Some confusion is forgivable. Khat and coffee were probably first cultivated in Ethiopia. Their names may both be etymologically related to "Kafa," the name of a place where they both flourished. Local folklore concerning the first use of coffee and khat is identical. Both involve a goatherd named Alexander who noticed friskiness in his charges after they had chewed parts of the plant. When he chewed the plant himself, Alexander found that he could pray and meditate for long hours into the night.

Early use of khat was in the form of a beverage that came to be known as Abyssinian tea — perhaps adding to the confusion as to whether caffeine was a constituent of khat. The tea was drunk for its medicinal properties. As much as they existed, the medicinal benefits of drinking Abyssinian tea likely lay in the use of boiled and therefore sterilized water and in the nutrients found in khat — which include ascorbic acid, niacin, beta-carotene, and calcium, often lacking in Ethiopian diets even at the best of times — rather than in its pharmacological properties. Abyssinian tea is also the name given to the dried leaves and shoots of the khat plant that are used to prepare the beverage.

Chemistry

The Hungarian pharmacognosist, Dr Kalman Szendrei, has written: "Although the history of khat chemistry goes back more than 100 years, it is still a rather puzzling chapter of natural products chemistry. . . . Just to mention the most striking and most frequent error in past khat chemistry: several authors overlooked (or were unable to take into account) that khat is consumed in most cases fresh and not as a dried material."

The active ingredient of khat is the chemical known as *l*-cathinone. It was discovered as recently as the 1970s at laboratories in England and Switzerland during investigations requested by the United Nations Commission on Narcotic Drugs. Cathinone is a highly unstable compound. On exposure to oxygen, it is converted to other pharmacologically active alkaloids also found in the live plant, chiefly *d*-norpseudoephedrine (NPE), sometimes known as cathine.

As mentioned earlier, the active constituent of khat was thought at first to be caffeine. Caffeine's absence was established in 1877, at which time another potentially active alkaloid was identified and given the name cathine. In 1930, cathine was found to be identical to NPE, which was already known from other work. In the early 1960s, researchers discovered that extracts from the fresh plant showed stronger effects on behavior than NPE and had a different chemistry. This realization prompted the initiatives that led to the discovery of cathinone.

What probably clinched the identity of cathinone as the active ingredient of khat was the finding that the cathinone content of khat correlated well with its market price. The best khat comes from Kenya, where the cathinone content reaches 3.5% of the dried weight equivalent of the plant. Fresh khat from the Yemen and Madagascar can contain less than 1% cathinone.

Cathinone and NPE are very similar in chemical structure to *d*-amphetamine, as shown here in the diagram. They have similar pharmacological properties, the main differences being in potency. A given dose of amphetamine generally produces a slightly stronger effect than an equivalent dose of cathinone, and about eight times the effect of an equivalent dose of NPE. Khat, to use the title of the latest WHO report, is thus "an amphetamine-like plant material."

As well as cathinone, NPE, and other alkaloids, khat also contains a variety of volatile components, flavinoids, fatty acids, and tannins, many of which may contribute to the attractiveness and activity of khat. The chemistry and pharmacology of khat continue to be very active areas of investigation.

Pharmacology

Further evidence that cathinone is the active ingredient of khat came from animal studies of the pharmacology of cathinone. They were reviewed in the recent WHO report by Drs Peter Kalix and Inayat Khan. The table here is adapted from that report. The authors noted that each of the effects of cathinone has also been reported as an effect of amphetamine.

In humans, khat has also been reported to cause logorrhea (pathologically incoherent, repetitious speech) and euphoria. The effects on sexual activity have been reported as mixed. Khat has been said to cause both an increase in desire and performance and a reduction in them. Some authors have said that different varieties of khat produce different effects, not only on sexual appetites but also on mood, some varieties being "uppers" and some "downers." There is unanimous agreement among users of all forms of khat and their observers that khat causes thirst for fluids, but this does not seem to have been confirmed by experimental studies.

Other reported effects of khat and cathinone are analgesia, gastritis, constipation, and an increase in excretion of catecholamines. Cathinone has been found similar to amphetamine in a number of neurochemical measures, including dopamine depletion and blockage of dopamine uptake. Tolerance has been demonstrated to the effects of both khat and cathinone, and partial or total cross-tolerance has been found among cathinone, NPE, and amphetamine. After-effects of khat use have been reported as insomnia, numbness, and lack of concentration.

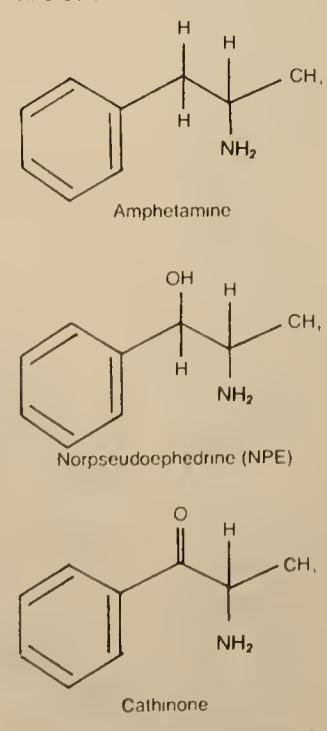
* * *

In June I shall write about how and where khat is now being used, what is being done about its use, and whether the medical and non-medical concern about khat is justified.

TABLE

Common features in the effects of khat in man and of cathinone in animals.

Effects of khat chewing in humans	Effects of cathinone in animals
Anorexia	Anorexia (rat, monkey)
Insomnia, lack of fatigue	Restlessness (monkey)
Hyperactivity	Hypermotility (mouse, rat)
Excitation	Stereotyped oral activity (mouse, rat, rabbit)
Hyperthermia	Hyperthermia (rabbit)
Increased respiration	Increased oxygen consumption (rat)
Mydriasis	Mydriasis (monkey)
Arrhythmias	Positive inotropic and chronotropic effect (guinea pig atrium)
Hypertension	Hypertension (cat)
Compulsive khat consumption	Cathinone self-administration (monkey)



Chemical structure of cathinone and NPE (found in khat) and amphetamine.

EDITOR
Anne MacLennan

PRODUCTION EDITOR
Terri Etherington

CONTRIBUTING EDITORS
Karin Maltby (Toronto)
Harvey McConnell (Washington)

CONSULTANTS
Dr Oriana Josseau Kalant
(Science)
Robert Solomon
(Law)

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053 Advertising 595-6113. Subscriptions 595-6056

CORRESPONDENTS

John Carroll (New Brunswick)
Maureen Brosnahan (Winnipeg)
John Dornberg (Munich)
Manfred Jager (Winnipeg)
Tom Land (London)
Betty Lou Lee (Hamilton)
Allan Massam (London)
Lachlan MacQuarrie (Hong Kong)
Jean McCann (Cleveland)
Pat McCarthy (New Zealand)
David Milne (Toledo)
Tim Padmore (Vancouver)
Lynn Payer (New York)

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Readers want more on familial alcoholism

Families feature excellent

We are interested in receiving an information package, including bibliographies of papers presented at the American Psychological Association, (The Journal, Oct 1984), on children of alcoholics, Families and alcohol: a legacy of love and pain.

Carol D. B. Whaley
Coordinator
Employee Assistance Program
Calgary Board of Education
Calgary, Alta

I read with great interest your article on Families and alcohol: a legacy of love and pain (The Journal, Oct 1984). The copy I read belonged to a friend of mine.

I would be very interested in receiving this special section, along with bibliographies of the papers excerpted. If you have any other material pertaining to the family and alcohol, I would appreciate receiving this also, as my family has been greatly affected by alcohol. I have two children ages six and 11.

Shirley Ward
Newcastle, NB

Thank you for a most enlightening article on children of alcoholics, Families and alcohol: a legacy of love and pain (The Journal, Oct 1984).

Could you please send us an information package and bibliographies on the subject.

We appreciate your excellent publication.

Jacques Perras
Program Director
La Maison Jean Lapointe Inc
Montreal, PQ

Researchers seek info

The Journal (Sept 1984) reported comments on drunk-driving controls made by Dr Paul Whitehead at the 25th Annual Institute on Addiction Studies.

Much of the research conducted by my colleagues and I appears to have objectives similar to those of Dr Whitehead's work.

I would, therefore, like to correspond with Dr Whitehead with a view to exchanging information and ideas.

Unfortunately, I do not have his address, and would greatly appreciate it if you could either supply me with a postal address, or forward this letter to him.

Rudolph Deppe
Council for Scientific and
Industrial Research
National Institute for Transport
and Road Research
Pretoria, South Africa

Editor's note: A copy of your letter has been sent to Dr Whitehead.

Lifestyle guide on computer

The Oct 1984 issue of The Journal contained an interesting reference to the development of a software package for home computers called "Positive Lifestyling." We are interested in contacting the developers of this package, and would appreciate your forwarding a contact address if it is available, or any other relevant information you may have.

Mary L. Routledge
Department of Health
Health Services Research and
Development Unit
Wellington, New Zealand

Editor's note: The Positive Lifestyling computer program is produced by Softworld Inc, 9550 Black Mountain Rd, Suite G, San Diego, CA 92126.

Elderly abusers a prime focus

Please send me any reprints or a bibliography of articles on alcohol and other drug abuse among the elderly.

As the prevention coordinator of the Alcohol Center in Huron County, I'm currently trying to find out more about the problem and the best way to begin dealing with it. There seems to be no printed material about this problem among the elderly.

I would like to commend you on your excellent publication. Our agency receives The Journal and I find it very informative.

Lisa Greene
Alcohol Center of Huron County
Norwalk, Ohio

Memorial service planned

TORONTO — A memorial gathering will be held at Hart House, University of Toronto, April 14, for Ruth Cooperstock who died after a lengthy illness here on January 31.

Ms Cooperstock, a senior scientist in the epidemiology and social policy research division of the Addiction Research Foundation (ARF), was a world expert on tranquillizer use. Her book, *The Effects of Tranquillization: Benzodiazepine Use in Canada*, co-authored by Jessica Hill of Health and Welfare Canada, is recognized as an important international contribution.

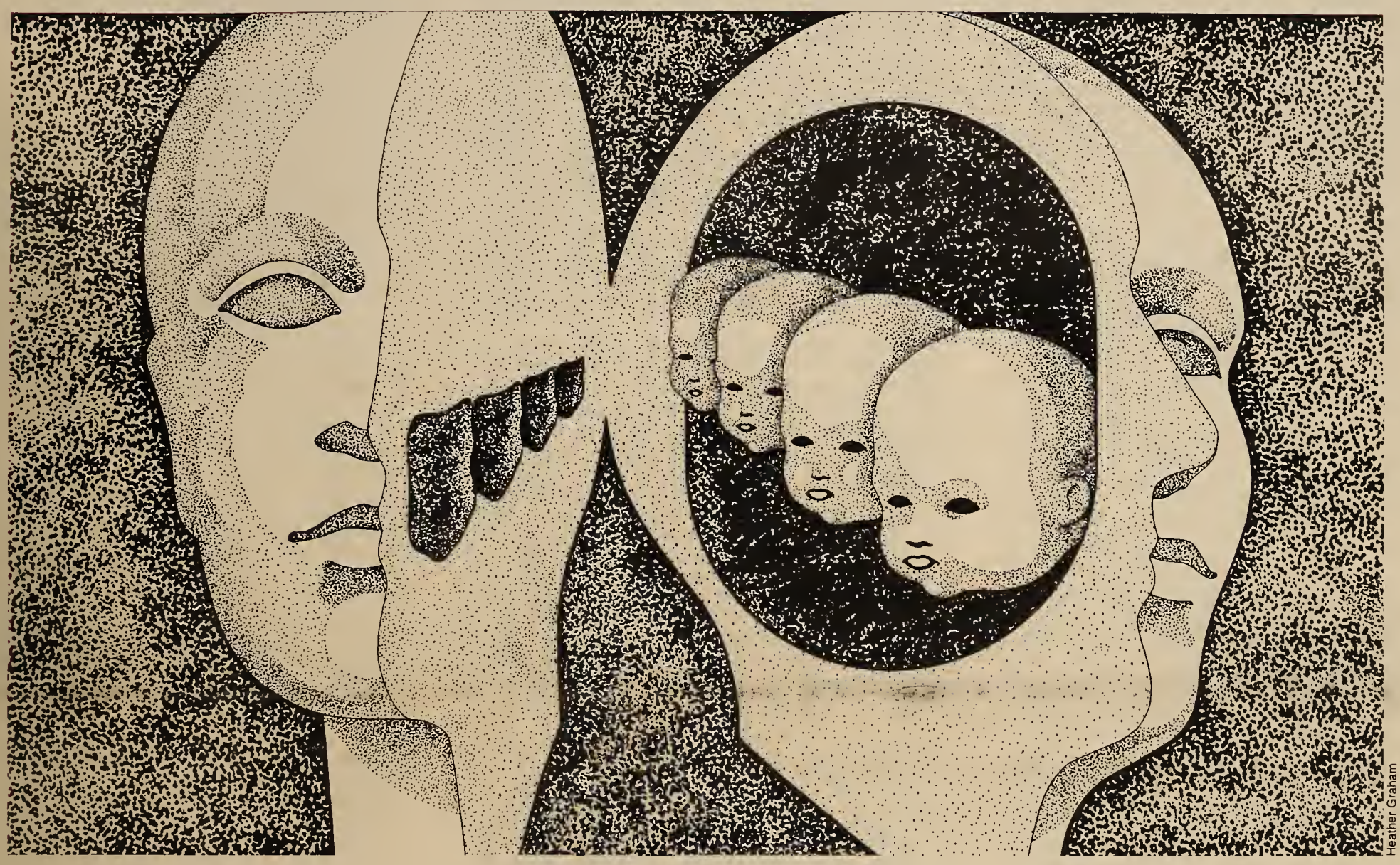
Ruth Cooperstock

Her primary research focus had long been in the area of overuse of minor tranquillizers by women. More recently, she had been studying the effects of these drugs on the elderly.

Ms Cooperstock came to the ARF in 1966. She studied sociology at Sarah Lawrence College, New York, and worked as a research officer and consultant at Columbia University, New York, before moving to Canada in 1965. She was a research sociologist in the psychiatric unit of the Saskatchewan department of public health until her move to Toronto in 1964.

Friends and colleagues will join Dr Henry Cooperstock and their two children Dan and Sue in honoring Ruth at the memorial service.

The Children Remembered



Heather Graham

Echoes of parental alcoholism linger on

In recent years, there has been an explosion of interest and activity in what many view as the newest social movement within the field of alcoholism.

Momentum is gathering, in the United States at least, for research on, and education for, children of alcoholic parents. These "survivors" of familial alcoholism are networking into self-help groups, and also into a continent-wide assembly — the US National Association for Children of Alcoholics (NACoA).

Although Canadian social worker Margaret Cork is recognized internationally as a pioneer in the field, because of landmark research which resulted in the 1969 publication of *The Forgotten Children*, there is no comparable, organized movement in this country. And, there is little evidence, in Canada, of any major research or treatment thrust, although pockets of interest and programs are beginning in such areas as Alberta.

In February, in Orlando, Florida, a handful of Canadians, amidst a 1000-strong US contingent, gathered for the first national conference of the NACoA. The group was composed of educators, therapists, and other health professionals. Many shared the common bond of dual interests. Professionally, they were there to garner the latest research on children of alcoholics. On a personal level, many attended also to understand themselves better as "adult-children."

The speakers, professionals who, by-and-large, publicly acknowledged themselves as adult-children, categorically state there are still many unanswered questions. However, the NACoA, in its charter statement, has assembled statements about this group as established facts, and it was on this basis, and in this spirit, that speakers presented their findings.

The NACoA charter states, in part:

- **"Children of alcoholics (COA's) of all ages share a common bond.**
- **We define COA's as people who have been impacted by the alcoholism of a parent or another adult filling the parental role. COA's have an adjustment reaction to familial alcoholism which is a recognizable, diagnosable, and treatable condition.**
- **COA's continue to be ignored, misdiagnosed, and undertreated.**
- **The problems of most COA's remain invisible because their coping behavior tends to be approval seeking and socially acceptable. However, a disproportionate number of those entering the juvenile justice system, courts, prisons, mental health facilities, and referred to school authorities are COA's."**

Sharon Wegscheider-Cruse, a recognized US authority on adult-children, said this of Margaret Cork's work: "I think we were forgotten, and some of that forgetting has been blatant and clear abandonment. For others, it was more subtle, but just as devastating. We refuse to be forgotten, ever again."

The Journal presents Part I of The Children Remembered in recognition of adult-children and because of overwhelming, positive feedback from readers on an earlier piece — Families and Alcohol: A legacy of love and pain (Oct 1984).

Maltby

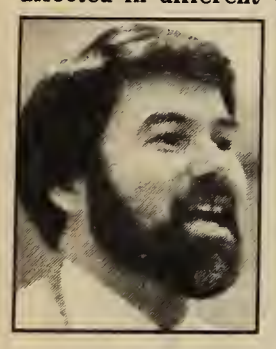
Karin Maltby, contributing editor of The Journal, attended the conference and prepared this report which encapsulates and synopsizes presentations by several speakers. Part II will be published next month.

'No one ever keeps a secret so well as a child.'

Victor Hugo

Children of alcoholics and human development

Children who grew up with parents burdened by chemical dependency have been categorized, in recent years, by catch-all phrases such as adult-children of alcoholics. Although these people share many similar pains in dealing with unresolved childhood issues, as individuals they are affected in different ways and to different degrees. So says Robert J. Ackerman, PhD, who has published, lectured, and trained others on adult-children. Dr Ackerman, professor, department of sociology and anthropology, Indiana University of Pennsylvania, Indiana, Pennsylvania, outlines some of the major areas of concern for adult-children, and addresses their differences in development.



Robert J. Ackerman

Some people think that the phenomenon of children of alcoholics has just begun. But we've had alcoholics for thousands of years, and, consider this: there are more children of alcoholics in the United States than there are alcoholics.

Why have they been quiet so long, why have their needs been overlooked, and why is each of them affected differently by parental alcoholism?

Children are all affected by their parents who drink, but they are not all affected in the same way. They are affected by degrees.

The human services field today is filled with people from alcoholic homes. For these nurses, doctors, teachers, and so on, life hasn't been all catastrophic. It is not where they came from that is the single determinant; it is what they have learned from their experiences.

In the same family, there may be three children of alcoholics. One is totally devastated by the experience, to another life is a trade-off, and the other person, in spite of everything, manages to do very well.

I would like to consider why people are affected differently from a concept of human development. How were they affected developmentally? What kinds of impacts might therapists want to look at?

As therapists, I think we suffer two major deficiencies relative to children of alcoholics. One is that we may have a conceptual deficiency and are not sure what the term adult children of alcoholics means. Two is that someone may make the statement: "Children of alcoholics should be in treatment." However, what would you treat them for?

I would argue that children of alcoholics have multiple needs and interests. For example, an alcoholic who attends Alcoholics Anonymous meetings has a singular goal. With children of alcoholics, however, the needs are likely to be highly diversified, and to different depths and to different degrees. They should be in treatment, but treatment for what?

We also have a perceptual deficiency. That is, what does being a child of an alcoholic mean to that person? It does not mean what I say it means. I must interpret from that person's point of view — listen, share, and pick up his perception.

Theorists divide our lives into stages when looking at human development. They argue that there are normal, developmental crises that all people go through at each stage, and that these stages occur sequentially. The idea is that there must be some sense as we go through our lives.

However, a common feeling from so many adult children of alcoholics is: *"I feel like I missed my childhood. When I was a child, I was never young."* It would be nice if that child could be a little girl before someone asks her to take on the responsibilities of an adolescent or an adult. It would be nice for a little boy not to hear "act like a man."

To a great extent, many people raised in troubled families have had to accelerate developmentally in certain areas.

Children of alcoholics, incidentally, do not have a market on troubled families. People from all troubled families will identify with children from alcoholic homes.

There is also an argument which says the development of a child from a troubled family can be arrested, impeded, or accelerated. Of course, the child cannot be accelerated physiologically, but he can be overloaded emotionally at a very young age.

Therapists see many people in their 20s and 30s who don't have specific problems, but many problems in general. They appear to be "burned-out" because they were taking on adult responsibilities by the age of 12 or 13.

If development is taken out of sequence, and an adult wishes to relive the adolescence she missed, for example, she will be chastized and labelled as terminally adolescent. On the other hand, adults are pleased when, at age 12, an adolescent acting in an age-inappropriate role assumes responsibility for the entire family. This is irony.

The best time to engage in childhood activities is when one is a child, because then they are normal. But, if an adult child of an alcoholic tries them at a different point in time, he may be just as much out of step as he was initially when someone overloaded him with an adult role.

There is also a building-block assumption which says that as we go through our lives, how well we do at one stage sets the scene for the next. It means that if a person cannot resolve the issues of one stage, she will not have the luxury of leaving them behind. This is the theory of eternal yesterday. She will take them with her again, and again, and again. For example, adolescents from alcoholic homes hypothesize that once they can leave home they will leave their problems behind. However, they find out they don't have the necessary emotional ingredients to improve their lives. They may not be drinking but they may be on a "dry drunk" — the inability to share, to risk, to grow, to say no.

Another variable is the situational crisis. It occurs when the adult child of an alcoholic believes he is powerless to change the outcome of a particular situation. Someone else with more resources, however, would not perceive the same situation as an unmanageable crisis.

Adult children of alcoholics feel powerless about a minimum of three issues.

They are powerless to get their parents to stop drinking. In our adult-children's groups, we must pound one thought into their heads: children of alcoholics cannot get sober for their parents. They understand it, but they do not believe it.

They are powerless also about the relationship between their parents. We know that children are far more upset by the relationship between their parents than they are about the drinking. Here are two people they love who aren't getting along. Small children carry this thought into adulthood: *"If I were better, it would be better. If I could please my parents, they would get along better."*

If children of alcoholics are of a young age, they are also powerless to leave their environment. As therapists working with them, we too feel that powerlessness, and we feel those kinds of pain. G. Stanley Hall argues that adolescence is the most critical developmental stage. What, then, is the effect on resolving an adolescent's normal development while she is simultaneously experiencing a situational crisis of alcoholism in her family? Does that make the resolution of her normal developmental conflicts that much more difficult? For some adolescents there's a resounding yes; for others there's a trade-off, and others are still able to grow.

I believe there are a minimum of seven intervening variables as to why children of alcoholics, regardless of age, are affected differently.

• **Master-status role** — How severely does the alcoholism keep a parent from performing his master-status role as parent? The child is concerned only with his master-status role, and not with how well or poorly the parent may function on-the-job.

• **Type and kind** — We need to look at what type and kind of alcoholic the child lives with or grew up with. What is the personality type of the alcoholic, or, what is the kind of behavior that he or she engages in?

Children have a magnificent ability to divide a parent from his or her behavior. A child can say: *"I hate it when mom is drunk. I can't stand it when my dad is drinking. But, it doesn't mean that I hate mom and I can't stand dad."*

Behaviors of the alcoholic vary. For instance, a child may be exposed to an alcoholic who simply passes out, one who is verbally belligerent, one who is physically abusive, or one who considers life a joke.

• **Perception** — This is the most important variable. What is the perception of the child relative to living in this experience? Some children of alcoholics are very similar to children who are physically abused, and that is, they don't consider themselves abused until certain things are pointed out. Many children from alcoholic homes know their home is somehow different, but they're not convinced the differentness is negative until they can compare.

It's very difficult to get an adequate perception in an alcoholic home because there are high degrees of role inconsistency. Consider this example: an alcoholic parent is likely to fulfil his role when he's drunk, when he's got a hangover or feels guilty or remorseful, another time when he's fairly straight, and yet another when there's a lot of anxiety and agitation, usually before drinking. In our society, the scenario would be: Friday and Saturday "all hell is breaking loose;" Sunday is coming down, hangover day; Monday is guilt and remorse; Tuesday and Wednesday are fairly normal; and Thursday, which evokes anxiety and agitation, leads up again to Friday.

The non-alcoholic spouse in that family is always under stress, strain, and duress, and, as a result, acts in an inconsistent manner. The child from that home thinks of the alcoholic parent like this: *"When you're drunk I have to act a certain way; when you're sober I have to be a certain way."*

One of the hardest things for a child in an alcoholic family is to get a perception of what's going on. The *modus operandi* of the house is mixed messages and paradoxes.

There's no room to talk about alcoholism in the house and so the child must now verbally deny what he physically sees.

A lot of people in alcoholic homes begin to gravitate toward adapative-pattern behaviors. The key to surviving in these families is based on one's ability to adapt, but what price is paid?

Sharon Wegscheider-Cruse has written, "the ability to survive nonsense requires manipulation," and I would argue that this manipulation goes on at two levels. The alcoholic will manipulate the rest of the family so she can continue with that behavior with a minimal amount of confrontation. And, members of the family will learn to manipulate themselves.

One of the strongest reasons children of alcoholics adapt, and adapt, and adapt is that they do not want to be abandoned. They will do many things which may not be healthy because of the fear of physical or emotional abandonment.

The classic master-status roles which have been postulated (**The Journal**, Oct 1984) are hero, scapegoat, mascot, and the lost child. I think that all children of alcoholics simultaneously possess all four of these roles in their lives at any one time, although they may identify with being one more than the other.

I would add four additional roles.

Many children of alcoholics suffer from **hypermaturity**. These people act more mature emotionally than what is expected of them based on their chronological age. While the hero needs to lead, the hypermature hold a serious attitudinal disposition about themselves. They're always a little more mature and more responsible than their peers.

Enablers/placaters have the job of minimizing confrontation in the alcoholic home. These are children literally born with a degree in social work. By placating others, these children allow events to occur rather than dealing with them.

Another role is that of the **detacher**. This is the adult child of an alcoholic who says: *"I don't want to talk about it. It's over, it doesn't have any impact on me whatsoever."*

There are also people from alcoholic families who fall into the category of **invulnerable**. These are children who are doing very well, although one imagines they should be in every kind of treatment program. It would be easy to confuse the invulnerable with the hypermature or the hero because they all appear competent. The difference is that the invulnerable adult child of an alcoholic will admit and do something if he feels vulnerable. The hero and the hypermature will not.

• **Gender** — What is the sex of the parent who is the alcoholic, and what is the gender of the child? What is the impact on children, regardless of age, if mother is an alcoholic rather than father? Do sons of alcoholic mothers have a different perception than daughters of alcoholic mothers?

We haven't checked these questions empirically, but clinically we could do it today. Daughters of male alcoholics in the US disproportionately have wound up marrying men who *become* alcoholic.

If a woman is married to an alcoholic, and their children are aged eight and under, nine out of 10 times, that woman will stay with her husband. But, if the situation is reversed, only one out of 10 husbands will stay.

There are three possible combinations: both parents alcoholic, mother only, or father only. We've looked at quality of child care, family stability, and child abuse and neglect.

Where both parents are alcoholic, we found the worst quality of child care; they ranked middle in family stability, but they were high on child abuse and neglect.

In families where the mother was alcoholic, we disproportionately found single-parent families because the husbands had left. These families ranked in the middle on child care,but they had the lowest level of family stability.

middle on child abuse, but highest on neglect.

Families where the father was alcoholic ranked highest on quality of child care, had the highest level of family stability, and the lowest level of child abuse and neglect. In high probability, the women stepped in and took over many of the responsibilities.

• **Age** — Was the child born into an alcoholic family or did a parent become alcoholic when the child was five, 15, or 40 years of age? The longer the exposure to active alcoholism, the higher the probability of negative effects. Perhaps we should have age-appropriate intervention. An eight year old does not want to know everything an adult does about children of alcoholics. The younger the child the more I believe that counselling is more important than therapy.

• **Offsetting factors** — Text books say we get our primary relationships from our family, but a lot of people get primary relationships outside of the family, and some never have the opportunity to get them at all. Offsetting factors then, are people outside the family, institutions, schools, and programs which have impacted strongly on the child and continue to support him.

• **Culture** — To ignore the cultural considerations and the differences among us is to be naive. I'm talking about those things that are different racially, ethnically, religiously, and so on.

Finally, I do not believe that everything in life is negative for the child of an alcoholic. Some of the positive traits she has today, although painfully derived, serve her well. Some of her attributes did not come with ease. They came from growth.

Adult-child treatment issues in relation to new research findings

Because of increasing public awareness, many people now identify with, and define themselves as, adult children of alcoholics. They are demanding therapy geared specifically for them, says Claudia Black, PhD, MSW, president of ACT (Alcoholism, Children, Therapy), Laguna-Niguel, California. In prioritizing treatment issues and guidelines for adult-children, Dr Black cautions other therapists about the importance of empathy. She says: "When a 42-year-old adult child of an alcoholic walks out of my office, I want to sit back, I want to breathe, and I want to reflect. If I don't do that, I'm not feeling the emotional pain of the adult-child."

Claudia Black

I define the adult-child as an adult-aged person who was raised in a home where there was chemical-dependency, and the primary drug was alcohol. Typically, if there were secondary drugs abused, they were probably prescription pills or marijuana. I have not worked with children where the primary drugs abused by parents were heroin or cocaine.

When I speak about adult-children, I do not mean to imply adults who behave as children. I believe that these are people who, while they have the mental and physical resources of other adults, are still as emotionally vulnerable as small children.

If the words adult-children are difficult for some to accept, there are other definitions. Some therapists refer to this group as adult offspring from chemically dependent families. Others refer to them as grown-up kids from alcoholic families. However, I have found that my clients find the terminology adult-children very soothing. This particular terminology legitimizes and encapsulates their experiences and pain, and offers them an identity which allows them more in their lives than just the ability to survive. They do not perceive the term as patronizing.

We know that children from alcoholic homes had a loss in relationship to their addicted parents. As one parent becomes increasingly preoccupied with the need to drink, the non-addicted spouse in the marriage becomes increasingly preoccupied with the alcoholic's thoughts, behaviors, and feelings. The non-alcoholic spouse is not able to attend to his or her own needs on a consistent basis, nor is he or she able to attend to the needs of the children on a consistent basis. As a result, children experience loss in relationship to both the chemically dependent parent and the codependent parent.

Adult-children cannot recover without going back into the past. They must grieve the losses in their lives and connect what has occurred in the past with the present. Only then are they in a position to take responsibility for how they'll live the rest of their lives.

The goal of treatment, then, is teaching adult-children to take responsibility for their lives. The client must go back into the past and say: *"It wasn't fair, it wasn't right, and I deserve more."*

As therapists, we expect a lot from adult-children and want them to achieve things in treatment they are not yet capable of doing. Because they have experienced much loss in their lives, therapists must enable them to grieve.

Many kids in alcoholic homes are able to be very descriptive about what has taken place in their families and can recall horror stories. Many, however, are not able to be descriptive. There was no pushing, shoving, and slamming. There were no violent arguments, harrowing rides in cars, or embarrassing scenes at school events.

Many of these people were raised in homes where the drinking style was much more passive. For this group it's what did not take place that is traumatizing. Perhaps it was a father who passed out in front of the television set every night: *"He didn't embarrass me in front of my friends. He didn't berate me nor belittle me."* Therapists, must ask then: *"What didn't you get to hear from your father? What didn't you get to do with your mother because she was sick all of the time?"*

So, for kids who come from homes where the drinking-style was passive, therapists must help to make tangible their losses by helping them to identify what didn't take place.

I am not here to blame alcoholic parents. I believe people make decisions about whether or not they are going to drink, but they do not make choices about becoming alcoholic. Addicted parents also lose choices — about their parenting. And, there are no choices about codependency. That is the most natural response to being intimately involved with a chemically-dependent person. And, codependent spouses too, lose choices about how they parent their children.

I work with adult-children who are, most often, in their 30s and 40s, many times in their 50s, sometimes in their 60s, and, occasionally, in their 70s. Most often these clients will not experience the consequences of parental alcoholism on such a consistent basis that they even begin to ask for help when they are in their 20s. For adult-children in their 20s, it takes a few more years before they recognize they're unable to resolve their problems by themselves.

For example, someone 31 years of age, and in her third marriage, doesn't understand why she can't maintain a relationship, or a 34-year-old man isn't able to stay in a relationship long enough to consider marriage. There may also be difficulties with parenting or keeping a job. Ironically, any successes are not enjoyed.

People who seek therapy in their 30s, or later, are embarrassed that they feel the need to talk about childhood issues. They must be reassured that they couldn't have sought help any sooner in their lives. They must remember that they haven't had the resources other people have had.

Since a young age they've internalized blame and experienced powerlessness and helplessness. They don't trust the process of utilizing other people, and while they may have friends, they don't know how to talk honestly with them. Their physical reserves are low; they have chronic health problems and psycho-somatic illnesses. Many are now chemically dependent or are spouses of alcoholics. Many also have eating disorders.

Their perceptions are that God was unavailable to them as children, so they have also lost any essence of spirituality in their lives. They left their parents' homes with the belief they had survived. They do not know what they have not learned, but continue making important decisions without reflection upon the past.

The concept of adult-children is new and treatment has hardly begun. But many people are now able to identify themselves as adult-children and are demanding treatment geared specifically for them.

I tell adult-children who work with me that what once worked for them as children no longer works for them as adults. There is a price that has been paid. What is the price they paid for being so responsible, for giving up their childhoods by the age of three, or having taken care of everybody else's emotional well-being?

I want to validate that what they did was survive. They did what made all the sense in the world at the time, and they couldn't have done it any better. They want forgiveness now, forgetting they've had to respond to adult problems without the resources of adults.

Therapists should not take away those survival skills. The purpose of therapy is to try to bring a balance to their lives, and that needs to be stressed. Therapists should give adult-children some choices about how they protect themselves and how they relate to other people.

At each session, it is important to ask: *"Is there anything that was said today which you never talked about before, or which you haven't talked about in a long time."*

Adult-children, many times, will not show affect. Because they fear losing control, they will not cry, for example, until they're alone following a therapy session.

Adult children are "one and ten" kinds of people — all or nothing. A lot of what treatment is about is teaching them the numbers two through nine. Sometimes, we even use that language.

I do not ask them to give up all control; I ask them to give up some. In an exercise, for example, I will ask: "What is the value in being willing to give up some control?" They may respond with: "trust, relief, relaxation, spontaneity," and so on.

Therapists must have extreme patience because they are teaching clients something which they needed to learn as little children. They must reinforce the appropriateness of crying, as well. Clients may not know what they are crying about but, in time, will be able to connect the tears to a source.

Problem-solving with clients is important. For example, what would be of support to them in a healthy way? Should they cry when they are not in session? What do they need from the people they are living with if they get angry?

Adult-children should be told not to make any more major, life decisions than necessary in the first year of the recovery process because these decisions are very much affected by their childhood. The severing of a marriage, for example, might be a fine decision, but I suggest to clients that they not finalize divorce until treatment has progressed.

I don't want to have a stake in their decisions, but I do want to have a stake in how they make their decisions. I want those decisions to be free of the past, and based on who they can be today.

I have never been taught directiveness as a treatment style. I know in theory, that when clients make a decision, I'm supposed to stay detached, help them make good choices, but not be directive. In reality, however, that's not the best treatment for adult-children, or the best treatment for other people from chemically dependent families.

They're not in the best place to make their own decisions. I don't think they have learned how to make healthy decisions, and it's a therapist's job to teach them how to do that and then turn the decision-making over to them.

Adult-children often experience loss of recall, as if they were amnesiac for a period of their childhood. They simply are unable to recall anything during a portion of time, and it's usually a couple of years, or more. People often believe that a traumatic incident occurred to them that has caused their memory loss. Sometimes that's true, and sometimes it's been a series of very blatantly traumatic incidents, the ultimate being incest. That's usually the adult-child's perception: *"I can't remember, but I wonder if I was sexually molested?"*

Loss of recall does not occur just because of acute trauma. Adult-children experienced much loss, and they were children. Therapists forget that. However, I don't want to negate that when I find incest, I find more loss of recall.

A study of more than 600 adult-children found that daughters of alcoholics were two times more likely to be incest victims than other females. In an alcoholic home, mothers were four-times more likely to be physically violent. And, there is also the emotional incest, that is, a girl labelled a bitch and a whore when she's nine years old.

Therapists need to be careful about how they use touch with adult-children. Touch has not been a positive experience for them. Clients say, for example: *"The only time I got hugged by my mother is when she was drunk, and then she squeezed me so tight it hurt,"* or: *"I had to give my dad and all his drunken friends a hug everytime they walked out of the door."*

As a therapist, I don't get focused on trauma to help adult-children remember. As they have access to other adult-children, and access to material about what takes place in an alcoholic home, they begin to remember much of what they once forgot.

I think that we can use humor in the treatment process, but not as quickly as with other clients. My experience has been that adult-children don't laugh as quickly as other people do.

Is it an advantage for a therapist to be an adult-child? When I hire an adult-child, I want him to be a skilled therapist. I will not hire him just because he is an adult-child. His unresolved issues will interfere greatly with treatment. However, I do think it's of value for clients to know if a therapist is an adult-child.

Clients don't need to know much more than that. They may make general queries, but it's my belief clients don't want to know the personal issues of therapists, as adult-children.

My guidelines are that if a therapist talks about herself more than two minutes, or more than twice in a session, she's talking too frequently.

If an adult-child is alcoholic also, I prefer him to be sober for one year before he begins to be focused actively on adult-child issues. Alcoholic people like to be focused on anything other than what they need to do to stay sober. I don't believe that adult-child issues will sabotage whether the alcoholic gets sober, but I have no doubt these issues sabotage the quality of his sobriety.

Adult-children have great difficulty identifying a problem until it's a crisis because of their high tolerance for inappropriate behavior, their inability to set limits, and not recognizing normality. These are people who will end up drunk before they know they were building up to drink. As therapists, we need to help them see a problem before it turns into a crisis. →

'To live life to the end is not a childish task.'

Boris Pasternak

'Down in the flood of remembrance, I weep like a child for the past.'

D.H. Lawrence

Unfinished business

Sharon Wegscheider-Cruse defines codependency as "a specific condition characterized by preoccupation and extreme dependence on another person — emotionally, socially, and sometimes physically. This dependence, nurtured over a long period of time, becomes a pathological condition that affects the codependent in all other relationships." Ms Wegscheider-Cruse, MSW, is president of ONSITE Training and Consulting, Sioux Falls, South Dakota, director of training for the Caron Foundation in Wernersville, Pennsylvania, and a founding board member, and immediate past-president, of the US National Association for Children of Alcoholics. Obviously, she says, the family — whether it be nuclear, extended, borrowed, or institutional —has a profound affect on a person's growth into adulthood. What, then, happens to people in their professional lives, when they have grown up in families touched by alcoholism? Ms Wegscheider-Cruse suggests there are ways that codependent professionals can move to make better choices for personal freedom and professional direction.

Sharon Wegscheider-Cruse

If the child of an alcoholic is also a helping professional, they are exhibiting what we call the codependency syndrome.

The helping professions are a place where many adult-children have struggled to get their own treatment. I think they were drawn to these professions, at a very subconscious level, out of the need to make the world a better place than the one they came from.

Some codependents believe they did not come from any kind of painful family despite the fact there was alcoholism somewhere in the family system, or some dynamic that resulted in a rigid rule-system and emotional repression.

People can be emotionally repressed in any kind of family system which is rigid behaviorally and repressive emotionally. And that is found in every chemically-addicted family.

People from such families stop developing emotionally at the age when their parents become dependent on something outside of themselves to deal with their pain. Those born into a family in which prescription-drug dependency, or alcoholism, had already been a factor, can consider themselves emotionally handicapped; they did not live in an environment in which they could emotionally interact.

Those who experienced no parental alcoholism but alcoholism in grandparents, are also at high risk, because they grew up with untreated adult-children who passed the delusions, the repression, and the compulsions down through the system.

I believe that codependency is a primary disease. It is an identifiable, progressive, describable, and treatable disease. That is good news because if it is an entity which can be understood and treated, there can also be recovery.

Codependency treatment is not an intellectual therapy. Adult-children were not just affected in their heads. As a matter of fact, most are a little over-developed intellectually, so much so that it becomes a defence. Where they are underdeveloped, is where the disease ran rampant, and that's in their emotions. It's their hearts and souls which hurt.

Adult-children can't *think* themselves out of emotional pain. But, a healing of that pain results in the freeing-up of these people on a behavioral level.

Adult-children continue to make themselves ill the way they did as children by using old, learned behaviors and indulging in cyclical self-sabotage. They are not taking the next step by believing: *"I am responsible for my well-being as an adult. It is no longer my parents' issue."*

The disease of codependency has several symptoms and major complications.

The first of those symptoms is denial — that mismanaged thinking which makes adult-children believe they are powerless. I often ask them to complete the sentence *"I would like to . . . but."* What they say after the word "but" are some indicators of where their codependencies lie. They often finish the sentence with: *"but it's too risky, too hard, too fearful."*

Codependents have within them the power to face their illness and take responsibility. Their lives can change whether their parents' lives ever change.

Codependents suffer from a variety of compulsions. These compulsions can quiet fears, angers, hurts, and guilt. Unfortunately, this quieting is like chemotherapy gone too far. It also destroys such feelings as anger and hurt, which they need to discharge. They compulsively quiet their pain and, in the process, produce more pain. That's the addictive process of codependency.

Smoking is a codependent behavior. Non-smoking codependents go much further in the treatment process than those who continue to smoke. Smokers experience anxiety, tension, and feel they're going to "fall apart." That's the very pain they've been medicating with smoking for so long. Smoking plays havoc for them in areas of intimacy, sexuality, and relationships. It works as a barrier to potency and intimacy.

(As of January, 1986, I no longer can have therapists work for me who smoke because they are trying to be role models. And they can't do that and smoke at the same time.)

Another compulsion is frenetic activity. Codependents have to be doing something all the time. As adult-children they've always had to be accountable, and they're always trying to organize and manage. Because they grew up in a chaotic house, they believe the organization will make it better.

My experience with adult-children is that they're always "getting ready to get ready for when." I like to say to them: *"The show's on and the rehearsal is over, because this is it."* That can be very exciting or very depressing.

It's an important concept, because adult-children are always thinking about the time they will become who they are going to be. They believe that only then will they feel better and happier. I tell them to trust the messages they give themselves from the inside-out, and to realize that there isn't something out there to go and attain. They already have it, but can't see it, because they're living in a swirl of expectation.

As children, they believed that when they got out of their homes, when they could manage their own time, or when they got out and mixed with other people, they were going to find the magical kingdom. Most of them, if they had been listening to that intuitive child within, would see that they have had much more than they ever thought they had.

Codependents continue to quiet their compulsions with frenetic activity. They must do more, get more degrees, open bigger programs, add more staff, change things, and so on. They fear that someone else may do more. They're still waiting for someone to say: *"It's good enough. You've done enough. Take a rest. Be good to yourselves."*

Codependents also quiet their pain and self-sabotage by compulsively feeding their anger with food. Obesity is rage. It's covered-over rage, and codependents feed it and punish themselves with it. They punish themselves and others sexually with their obesity. It is their desperate cry for control to quiet their anger: *"I will not take anymore."* They may also be anorectic or bulimic. Both obesity and the other similar conditions are related to addictive behavior.

Compulsive eating is how they fight for some control of their lives. Obesity says: *"You may do this or that to me, but you will never get me to fight back."*

Another compulsive behavior which I see a great deal is sexual addiction. Angry adult-children are impotent or indulge in pornography. Fearful adult-children, both male and female, get involved in chronic, continual masturbation.

Work achievement, smoking, and sexual addiction are three compulsions I see most often. Dependency in relationships, and even on conferences like this, are other compulsions. I begin to see the same people attending conferences on adult-children everywhere around the US. And, when I talk to them — they say: *"I'm going to die if I can't be with this group of people. What's going to happen to me when this conference is over and everybody goes home?"*

Conferences and therapy are meant to be laboratories for change. They're not meant to be events where adult-children get all their good feelings. The work should be done at home with the people in their lives and with their jobs.

Some codependents working in the alcoholism field react to authority in the same manner in which they reacted to their parents. They're big on the outside, taking on responsibility, but they're little on the inside, and are not having their own needs met.

And so we see these overworked, overburdened, overtired people putting much time on the job. At the same time, however, they are unfulfilled. They don't know how to distinguish the job from the recovery program. And, when they get ready to think about getting their own needs met, they're afraid to speak up. When staff problems occur, they talk with each other about how awful mom and dad (authority figures) are. They think: "How can we survive? How can we punish dad?" They become groups of little kids complaining about the system.

Adult-children codependents tell me that the people who are decision-makers (bosses/authority figures) are sick. They are very good at collective complaining with no individual risk.

If someone is working in a system or a job where there is a "collective buzz," they should resign from that group and take their own risks. If they need to, they should resign from the job. The collective buzz will kill them.

Codependents have a hard time with taking job risks because they have bought into the scarcity principle. They believe they are only going to get one big chance. one possibility, one job, and, if they blow it, they'll never get another chance.

When we finally understand all we need to know about codependency and adult-children, we will begin to see that alcoholism, in its primary nature as a disease, is secondary to codependency. I have yet to meet an alcoholic that was not a codependent first.

Adult children become codependent on any compulsion or anything outside of themselves to give them relief. As children, they develop dependency patterns early and when sex, success, gambling, and chemicals, for instance, are available, they already have the dependency behavior as a result of having lived in an alcoholic family.

Consider any disease which responds to a medication. An adult child who begins to use alcohol may progress (three out of four times) to alcoholism. The alcohol medicates their codependent pain. When an intervention takes place, and the alcohol is removed, it's like removing the medication for any disease. We will see a symptom re-emergence. The codependency was waiting to re-emerge once the medication was taken away.

Codependents build monuments to suffering. They have a hard time believing that they really deserve good things and joy in their lives. Their compulsive behavior results in frozen, medicated, smothered, and dependent relationship feelings. They're sad, they're angry, they're shy, they dress in certain ways, and they're scared. They don't believe they deserve any more, so they're also satisfied. It's low self-worth in the deepest sense.

They think: *"I'm not worthy of a better life,"* or *"I'm not worthy to have a meaningful, happy, sexual relationship so I don't even try anymore, I don't even think about it. I hurt about it, but I don't let myself know that I hurt about it."*

Issues of worthiness result in medical complications. Codependents and adult-children are the most costly consumers of medical care. People cry out through their bodies when they don't take responsibility for their lives. It's a way of begging.

Small children who are codependents are highly asthmatic, have many allergies, particularly acne, and are accident-prone. As they get older, they struggle with anorexia, bulimia, and boys struggle with impotence. As they get older still, they face colitis, high-blood pressure, stomach problems, back and neck pain, and tight muscles.

The disease we find with greatest regularity is cancer, particularly of the breast, stomach and throat, and tumors. In my work with families, once I see a three-generational map of where there was alcoholism, I can often pinpoint either the cancer that has occurred or that will occur.

We are dealing with a life-threatening disease when we're dealing with codependency, and it's much too important to intellectualize about.

If people have been repressed for a while, and their feelings are on the surface, a therapist may guide them through the discharge of what I call the toxic waste of emotions which have been stored. Crying, for instance, discharges toxins.

Some people have emotional surgery, a potent form of Gestalt therapy where another level of consciousness is created. It should be done carefully and only with well-trained people because to do it otherwise would be like performing an operation and not suturing.

The Journal *would like to hear readers' comments on the issue of familial alcoholism and codependency. Write to: Letters-to-the Editor, The Journal, 33 Russell St, Toronto, Ontario, Canada M5S 2S1. A limited number of bibliographies and the mailing address for the United States National Association for Children of Alcoholics are also available.*

World war on drugs

Each year, the International Narcotics Control Board of the United Nations analyzes the drug control situation worldwide, with a view to keeping governments aware of existing and potential threats to the objectives of the international drug control treaties.

While it reviews the situation as it affects all countries, the Board gives special attention to those in which problems relating to drug abuse, illicit trafficking, and uncontrolled or illicit production of drugs are most acute, or where developments are of particular interest to the international community.

In its reports, the Board describes the problems; notes the weaknesses in national controls and compliance with the drug treaties; suggests improvements; and describes, as well as enforcement measures, some of the treatment and education approaches being tried.

The Journal **publishes excerpts from the Board's recently-released, annual report for 1984, concentrating, for reasons of space, on the sections of the report that reflect the remarkable range of drug-related problems that exists around the globe — in countries rich and poor, large and small.** EDITOR

NEAR AND MIDDLE EAST

There is a high incidence of opiate abuse in some countries of this region which remains a major source of opiates for the international illicit traffic. The potential local demand from the large numbers of opium and heroin abusers in Iran and Pakistan alone, expressed in terms of opium equivalent, might well be between 500 tons and 800 tons annually. In addition, available data show that more than one half of the heroin seized in North America, and around 70% seized in Western Europe, during the first seven months of 1984, originate in the Near and Middle East. The size and frequency of seizures continue to increase; seizures are now also being made in transit countries not previously affected.

Yet, with the exception of Pakistan where the estimated illicit opium production is thought to be insufficient to meet local demands, no other country in the region reports any significant illicit cultivation of the poppy. However, seizures within the region itself and within other regions, show that a vast amount of opiates originates in the Near and Middle East.

Afghanistan

In 1978-79, illicit cultivation of the opium poppy took place in at least 14 of the 29 provinces of Afghanistan and had continued on a sharp upward trend for several years. At that time, Afghanistan was one of the world's largest producers of opium for the illicit market. The local consumption, particularly in the north-eastern part of the country, amounted to some 10% to 15% of the total annual production. The balance entered the international illicit traffic.

The extent of current illicit production is not known. However, the government has reported substantial seizures in 1983 amounting to almost 15 tons of opium and 456 kilograms of heroin.

Egypt

Egypt remains a country where the abusive consumption, particularly of cannabis resin and opium, takes place. However, the reappearance of heroin trafficking and abuse is regarded as ominous for the future. Amphetamines and methaqualone are also increasingly abused. In 1983, law enforcement agencies seized a large amount of the liquid dexamphetamine substance, "Maxiton Forte," possibly manufactured in a Western European country. This quantity is more than twice that seized during the previous year. This trend appears to have continued in 1984. Egypt is a prime target for cannabis resin, originating mainly in Lebanon, as evidenced by the detection of multi-ton consignments from that country. Moreover, due to its position between three continents, Egyptian territory is being increasingly used as a transit point for drugs smuggled from east to west, often through the Suez Canal and Cairo Airport. In recent years, cannabis and opium poppy have been illicitly cultivated in some parts of upper and lower Egypt. However, vigorous government action has led to a significant decrease in such cultivation.

Islamic Republic of Iran

Until the 1979-80 growing season, when poppy cultivation throughout the country was prohibited, Iran had an opium maintenance program for registered addicts, who numbered 163,315 in 1978 and 160,000 in 1979. Between 1970 and 1979, the average annual licit production of opium was 157 tons, with a maximum of 374 tons produced in 1972 and a minimum of 26 tons in 1973. During the same period, annual average consumption of opium by registered addicts was 171 tons. A maximum of 225 tons were consumed in 1975 and a minimum of 86 tons in 1971. It was estimated that the number of unregistered addicts was much larger than the number registered.

Today, opium remains the main drug of abuse. Authorities estimate the number of abusers at one-half million. Heroin abusers, estimated at 100,000, mainly comprise youth in urban areas.

The authorities state that no illicit cultivation of the opium poppy exists in the country and that opiates abused orginate abroad. Large seizures are regularly made in the provinces bordering Afghanistan and Pakistan. In 1983, almost 3½ tons of heroin, more than one ton of morphine, and 35 tons of opium were seized.

Lebanon

Lebanon remains an important centre for production and trafficking, particularly of cannabis resin in large quantities, as shown by multi-ton seizures made abroad. A new development of concern is the increase in the illicit cultivation of the opium poppy.

Pakistan

While Pakistan has achieved a significant measure of success in reducing illicit poppy cultivation and promoting crop replacement programs, illicit consumption and trafficking are increasing.

Illicit cultivation continues in the North West Frontier Province (NWFP). Since the peak illicit production estimated at around 800 tons of opium during the 1978-79 crop year, production has steadily been reduced. For the 1982-83 crop year, it was estimated at some 63 tons. The Pakistan Narcotics Control Board (PNCB) believes that the 1983-84 crop will be reduced further.

Traffickers can be expected to use Pakistan for transit and also as an illicit market for the large and growing heroin addict population in the country. Large seizures being made, both in the country and abroad, show an increase in illicit trafficking is already occurring.

For many years, Pakistan has played an active role in the activities of the Commission and its Subcommission. The Board believes that close cooperation between the enforcement authorities of Pakistan and India could result in more effective action to reduce transit trafficking.

The large and growing drug abuse problem throughout the country affects as many as 1.3 million individuals. The smoking of charas (cannabis resin), produced within Pakistan, is the most common type of abuse followed by opium eating and smoking which remain widespread. Abuse of tranquillizers and of methaqualone is also spreading.

The most distressing development is the escalating abuse of heroin throughout the country. Four years ago, opium constituted the main opiate abused and there were virtually no heroin addicts in Pakistan. Today, as many as 120,000 to 140,000 people regularly smoke heroin. The authorities are developing a treatment program.

A national survey in 1982, up-dated in 1983, concluded that by the end of 1983 the number of regular opium users would total around 300,000 and heroin addicts 100,000. Furthermore, heroin addicts could be expected to increase at the rate of 40,000 annually.

Based on the daily consumption by opium and heroin abusers, expressed in terms of opium-equivalent, the domestic demand of all opiate abusers would have been around 240 tons of opium in 1983, or four times the estimated domestic illicit production of 63 tons for that year. This shows that illicit opium produced within Pakistan accounts for only a fraction of the overall demand, both domestic and foreign. Thus, the shortfall must be being met by traffickers utilizing their stocks or smuggling supplies into the country from abroad and/or obtaining additional supplies locally. This situation starkly demonstrates the need for expanded and coordinated regional and inter-regional action.

Turkey

The government perseveres in its vigorous fight against illicit drug traffic, including prohibiting and preventing the production of opium, and permitting the cultivation of the poppy exclusively for the production of unincised poppy straw and seeds. Illicit cannabis cultivation is also eradicated.

The authorities are also making a determined effort to stem the flow of drugs across the country which continues to be exploited as a transit trafficking route because of its geographical position.

In general, drug abuse does not, at present, constitute an important social problem for Turkey.

SOUTH ASIA

India

India is increasingly used as a transit country for opiates and cannabis destined for other regions of the world. This is demonstrated by the large number and amounts of opium and heroin seizures. Most of these opiates apparently originate in the Middle East, reflecting the extent of illicit manufacture and supply from that area. Some illicit cultivation of the opium poppy has been detected in India, but it continues to be on a limited scale. Some leakage from licit cultivation has been reported. Opium smuggling networks have been uncovered across several northern states. During the last few years, clandestine laboratories were detected and dismantled. Seizures of cannabis resin, ostensibly of Near and Middle Eastern provenance, and of cannabis from Nepal have also been increasing.

Seizure data show that some methaqualone of Indian manufacture is being trafficked in Eastern and Southern Africa. The government banned the manufacture, sale, and import of methaqualone as of January 31, 1984.

Opium use is mainly encountered among older age groups. Cannabis, traditionally abused particularly by industrial workers and plantation laborers, is now reported to be used to some extent in student circles. A certain misuse of psychotropic substances has been found to take place in affluent sections of urban centres. With regard to heroin, the authorities are aware of the danger caused by transit trafficking, which numerous examples show precipitates abuse among local populations.

As stated above, the Board believes that enhanced cooperation at the operational enforcement level between India and Pakistan could result in more effective action to reduce transit trafficking.

Sri Lanka

Sri Lanka's role as a transit point for opiates and cannabis resin has led to increased abuse problems in the country. Heroin seizures for the period January to June 1984 amounted to 23 kg, exceeding seizures made annually during the last five years. Heroin abuse among youth has escalated rapidly. In 1981, known abusers totalled around 50; by early 1984 this figure had grown to 2,000.

In May 1984, the government amended the Poisons, Opium and Dangerous Drugs Ordinance to include severe penalties for drug trafficking (The Journal, Dec, 84). A National Dangerous Drugs Control Board is also being established.

Nepal

Nepal is not a party to any of the drug control treaties and little information is received. However, cannabis is known to continue to be smuggled out of the country in large quantities. Abuse of drugs, including heroin, has become an increasingly serious problem.

EAST AND SOUTHEAST ASIA

Certain countries of the region remain major producers and suppliers of opiates for the illicit traffic, and the importance of extensive and accelerated poppy eradication is evident. Cannabis is also readily available, and trafficking in, and abuse of, psychotropic substances appear to be growing. Most countries are afflicted with severe drug abuse, associated in particular with the widespread availability of opiates.

The large amount of heroin being manufactured in the region indicates that chemicals essential for such illicit manufacture continue to be available.

Trafficking by individual couriers is more and more being replaced by trafficking in bulk consignments, primarily by sea. Trafficking organizations are becoming more multinational with members being recruited from several countries.

Burma

The government continues actively to pursue a comprehensive policy aimed at treating and rehabilitating drug abusers, providing alternative income possibilities for poppy farmers, eradicating illicit production, and interdicting trafficking. The international community continues to support the government's efforts through multilateral and bilateral programs. Since the middle 1970s, the authorities have launched extensive operations to destroy poppy cultivation and clandestine laboratories.

Opiates, together with other contraband goods, continue to be smuggled by armed caravans mainly across the Thai border. In 1983, seizures in that area included three tons of opium, 48 kg of heroin, and 900 kg of cannabis. The continued pressure along the Thai border has caused some traffickers to use routes toward the northwest and the south. Seizures of morphine during the first half of 1984 quadrupled the seizures made during all of 1983.

At the close of 1983, the number of registered addicts stood at more than 40,000 — mainly abusers of opium and some 7,000 abusers of heroin. The narcotics legislation was amended in March 1983 to increase penalties for addicts failing to register.

Thailand

Illicit opium poppy cultivation, which reportedly extended over some 18,000 hectares and produced some 145 tons of opium in the late 1960s, is estimated to have been reduced by approximately two-thirds by 1980. Further reduction occurred in the following two years. This favorable trend could not be sustained during the 1983-84 crop season when the area cultivated with poppy was reported to comprise some 6,000 hectares, representing an increase of 38% over the previous crop year. Actual opium production was limited to around 36 tons because of adverse weather conditions.

Illicit cannabis cultivation continues on a large scale, mainly in the northeastern part of the country. Some manual eradication campaigns have been carried out. Between 1,000 and 2,000 tons of cannabis were seized or destroyed in the fields, and planning for eradication in 1985 has already begun.

The authorities continue to pursue a vigorous campaign to interdict trafficking in opiates and cannabis. Opiates nevertheless smuggled into Thailand from Burma and the Lao People's Republic are destined not only for transit onwards to other countries but also for consumption by the large addict population in Thailand itself. Transit trafficking is directed particularly at other Southeast Asian countries, Western Europe, the United States, and Australia.

Although opiates, especially heroin, remain the main drugs of abuse, other substances, including organic solvents, are also increasingly abused. The presence of heroin laboratories in the south of the country, has resulted in increased opiate abuse by youths in this region.

Malaysia

Trafficking of opiates from Thailand continues, both for abuse within Malaysia and for transit to other countries. More clandestine laboratories have been discovered, mainly in the north of Peninsular Malaysia. The opiates are transported southwards across the Thai-Malaysian border to major towns and distributed by a network of criminal syndicates.

Heroin abuse causes the greatest concern, but other plants, cannabis, and psychotropic substances are also abused. Heroin abuse appears to have spread to East Malaysia which is being used as a transit point. Although there is some illicit cultivation of cannabis, most of the drug originates abroad.

Territory of Hong Kong

Bulk consignments of heroin from Thailand continue to be smuggled into Hong Kong. Opiates are transferred from Thai to Hong Kong trawlers in international waters. Clandestine laboratories for refining heroin have been detected. Numerous trafficking organizations exist. Illicit opiates continue to be readily available despite large seizures. Most of the opiates are of South-

FOR THE RECORD

east Asian provenance, but some originate in the Middle East.

The main drug of abuse within the territory continues to be heroin. There has been a significant increase in the number of young people being initiated into heroin abuse. Abuse of cannabis and psychotropic substances also take place.

The Phillipines

The country serves as a trafficking transit point mainly for heroin and cannabis originating elsewhere in the region. The government is now placing priority emphasis on enforcement.

OCEANIA

Australia

Abuse of opiates, often in combination with barbiturates and other sedatives, is a major problem. Other drugs abused include cannabis, cocaine, and psychotropic substances, in particular amphetamines. The easy availability of most of these drugs appears to meet a growing demand. Illicit imports of heroin, cannabis, and cocaine for domestic consumption are being interdicted with greater frequency. Most heroin seized originates in Southeast Asia, but in some parts of Australia a proportion of confiscated heroin comes from the Near and Middle East. Illicit manufacture of small amounts of heroin extracted from codeine preparations, purchased locally, has been encountered. Major sources of cannabis are the Near and Middle East and South Asia; illicit domestic cultivation also exists.

New Zealand

Reported drug abuse comprises illicit consumption of cannabis and its derivatives, morphine, heroin, buprenorphine, and LSD. Illicit cultivation of cannabis is widespread and has prompted counter-measures, including helicopter-borne eradication operations. As in Australia, cases of clandestine manufacture of morphine and heroin from non-prescription proprietary codeine preparations have come to light.

EUROPE

Eastern Europe

Almost all Eastern European countries are parties to both main drug control conventions. In general, drug abuse does not present a serious public health problem, and the number of abusers is small. Legislation in most countries provides that abusers undergo treatments. Abusers most frequently obtain their drugs through diversion from licit channels by falsified prescriptions or theft.

The territories of some of these countries are being used for transit trafficking of narcotic drugs, usually in an east-west direction. The authorities continue to concentrate their efforts on suppressing such smuggling.

Western Europe

The drug abuse and trafficking situation in Western Europe is grim and deteriorating. The number of abusers, involving even the very young, is growing, and the number of drug-related deaths is increasing in many countries. At a time when irresponsible recourse to dangerous, dependence-producing substances is rapidly on the rise, it is essential that there should be unbroken continuity of all control measures in all countries of the region. Inadequate exercise of drug control on the part of one government can affect the situation not only in that country itself, but also in other, particularly neighboring, countries.

Western Europe remains seriously affected by heroin abuse which is a major public health problem. For the last decade, the quantity of heroin seized has grown almost every year. In 1983, 1.6 tons were reported seized, some 40% more than the figure for 1982. The three countries in which amounts confiscated were the greatest are Italy, the Federal Republic of Germany, and the United Kingdom. In the United Kingdom, the practice of inhaling the fumes of heroin appears to be spreading because of abusers' erroneous belief that this method of administration does not cause dependence. Other countries most gravely affected by heroin abuse are France, The Netherlands, and Belgium. Seizure data show that in most of these countries, and in Western Europe in general, the major portion of heroin confiscated is of Middle Eastern provenance. However, recent information indicates that heroin of Southeast Asian origin, traditionally trafficked to Western Europe, is again increasingly available and augmenting supplies in the illicit market.

Cocaine seizures have sharply risen, growing from less than 1 kg 15 years ago to more than one ton in 1983. This rapid increase shows cocaine has become a major drug of abuse, and trafficking has gained a firm foothold in Western Europe. Most seizures were made in airports or in international trains en route from an airport to a country of consumption. The countries with the largest quantities seized, in order of amounts, have, until recently, been France, Italy, and Spain. The most recent order is: the Federal Republic of Germany, Belgium, France, and Spain, whereas seizures in Italy have decreased notably.

Seizures in Western Europe of cannabis and its derivatives reached an all-time high of 112 tons in 1983, more than one-third more than the figure for 1982. Cannabis resin predominates in the illicit market, with the Near and Middle East and North Africa as the most significant source areas.

There is also an upward trend in the abuse of certain psychotropic substances. The demand for amphetamines remains at a high level, especially in Scandinavia and the United Kingdon, but expansion of abuse geographically is occurring. During 1983, a total of 21 clandestine amphetamine laboratories were dismantled in Western Europe, the highest number detected there in any single year. Also, a growing demand for depressants has been noted, particularly in central and southern European countries. Reduced production of methaqualone and new legislative control measures have led to a decline in illicit traffic. However, considerable licit stocks are held in certain European countries, and attempts have been made to divert parts thereof.

NORTH AMERICA

Canada

Abuse of, and illicit traffic in drugs constitute serious and growing concerns. Cannabis and its derivatives remain the most extensively abused drugs and are widely available in practically all parts of the country. Cocaine is increasingly becoming the second drug of abuse in most provinces of Canada and its supply is plentiful. Recently, in connection with a cocaine seizure in Montreal, equipment and chemicals used for the conversion of coca paste into cocaine hydrochloride were also seized. This is the first cocaine laboratory discovered in Canada. There also seem to be ample quantities of heroin on the illicit market. Diversion of licit supplies of various opiates as well as benzodiazepines and pentazocine, occurs through thefts, robberies, and falsified prescriptions mainly in metropolitan areas. Clandestine manufacture of methamphetamine, phencyclidine, and cannabis oil presents enforcement problems. LSD available in Canada is manufactured clandestinely in that country as well as in the United States.

Mexico

Cannabis remains the most widely abused drug. Cocaine abuse is also reported, while heroin is mainly consumed along Mexico's northern frontiers and in large tourist centres. Non-medical use of stimulants and depressants also causes concern. Abuse of organic solvents by minors is a long-standing and widespread problem. The authorities have restricted the sale of such solvents to adults and only through certain designated business establishments.

United States

The abusive consumption of drugs remains a serious public health problem. Data obtained through a comprehensive monitoring network and research suggest that overall percentages of new and current abusers of a number of drugs within certain age groups are estimated to be decreasing or levelling-off. Nevertheless, patterns of heavier and more dangerous use, or use of more potent substances, occur among large subgroups of users.

Heroin abuse appears to have remained relatively stable in 1984, but its increasing use in combination with other drugs is resulting in rising heroin-related hospital emergencies. In some parts of the country, the problem is made more severe by the availability of higher-purity heroin. Heroin orginating in the Middle East remains predominant, although the proportion of heroin of Southeast Asian provenance has increased.

Abuse of, and trafficking in, cocaine continues to escalate. Emergency-room admissions attributed to cocaine have more than doubled in the past five years, in part as a result of the spread of more dangerous forms of abuse. The cocaine is processed mainly in Colombia, but during the last year, several clandestine cocaine-conversion laboratories have been discovered in the US, particularly in the Miami area. This development appears to have resulted from the increasing difficulty encountered by traffickers operating in South America to obtain essential chemicals.

Cannabis is the most widely abused drug and the number of people who use this drug once or more monthly, are estimated at more than 20 million. Demand is increasing for the potent variety of cannabis, sinsemilla, which is cultivated illicitly, primarily in Jamaica, but also in the US itself. A positive sign is the declining number of cannabis users among highschool seniors for the fifth successive year; this trend is attributed to education, changes in youths' underlying attitude toward drug use in general, and a decreasing percentage of teenagers in the population. Illicit cultivation of cannabis within the US has become more sophisticated and widespread. Colombia remains the major external source, but the supply from that country is declining and is likely to be reduced further.

The level of abuse of certain psychotropic substances remains a matter of serious concern. The most widely abused substance is diazepam which, in terms of reported hospital emergencies, exceeds all other drugs, including heroin. One reason diazepam is being increasingly abused and trafficked is the drastic reduction of methaqualone supplies as a result of better control, both at the international level and within the US. In respect of other substances, amphetamines, phencyclidine (PCP), pentazocine, and LSD are also prominent drugs of abuse.

THE CARIBBEAN, CENTRAL AND SOUTH AMERICA

During 1984, representatives of a number of governments in the region have jointly issued a declaration solemnly setting forth their conviction that trafficking in narcotic drugs constitutes a crime against humanity and proposing measures to assist in the fight against such trafficking. This position has been endorsed at the ministerial level by the Inter-American Economic and Social Council of the Organization of American States (OAS). Its resolution, *inter alia*, emphasizes the importance of taking vigorous, urgent, and collective measures against illicit traffic and proposes a number of steps to obtain this end. In addition, authorities of a number of countries have held discussions concerning various aspects of the trafficking question. One such discussion, which included Brazil, Colombia, and Venezuela, concerned the serious problem of the expansion of the illicit cultivation of the coca bush.

The negative and destabilizing effects of drug trafficking, both economically and politically, are becoming ever more evident in some areas. The authorities recognize the need for urgent and vigorous intervention to prevent the huge financial profits generated by the illicit traffic from undermining legitimate economies and political institutions.

Drug abuse is spreading rapidly in many countries of the region. This is true particularly in producer and transit countries.

Bolivia and Peru

The uncontrolled and illicit cultivation of the coca bush invades entire regions and involves large numbers of farmers. Significant reduction of such vast production necessarily requires large-scale eradication and law enforcement programs, as well as integrated rural development.

Last year, the government of Bolivia committed itself to a five-year program to reduce coca production. The program is to begin in the Chapare area, considered the main coca leaf producing region. The reduction is expected to be accomplished through voluntary and mandatory eradication. The eradication program in the Chapare area is part of an overall plan to re-establish order in the area, to exercise tighter control over the transportation and marketing of coca leaf, and to provide alternate sources of income for farmers, as well as the infrastructure required for legitimate crops.

In Peru, some progress has been made toward the implementation of programs for the control and reduction of coca leaf cultivation in the Upper Huallaga region. Eradication operations under bilateral project agreements started in 1983. During the first six months of 1984, nearly 900 hectares of coca were eradicated in the Upper Huallaga Valley.

The government is concerned about a possible link between drug traffickers and armed disturbance against social order. Accordingly, it has intensified enforcement efforts. Arrests as well as seizures have been made which include narcotic drugs, precursor chemicals, arms, and explosives. Furthermore, 28 clandestine airstrips were destroyed in one enforcement operation.

The Board wishes to reiterate that the control of coca leaf production is the key to curtailing cocaine availability in the illicit market and the widespread abuse of this substance. In spite of formidable difficulties, it is essential that Bolivia and Peru, the world's two main producing countries, reduce their vast and uncontrolled production of coca leaves to the modest legitimate medical requirements for cocaine and for the limited industrial use of coca leaves. The Board recognizes that this long and arduous process, which must include the progressive reduction of coca chewing, requires not only the firm and sustained political commitments of the countries concerned, but also energetic efforts supported by assistance from the international community.

Colombia

The fight against illicit drug-related activities, which has been progressively intensified, reflects the increasing awareness on the part of both the government and the people, of the detrimental impact of large-scale drug trafficking on the country's political, economic and social fabric.

The growing abuse in Colombia, resulting from the ready availability of cannabis, coca paste, and cocaine, causes widespread public concern. As in the case of Peru, one particularly hazardous modality of abuse which has created a serious public health problem involves the smoking of a mixture of cannabis and coca paste. The government has accelerated prevention, treatment, and rehabilitation.

Brazil

In the past, Brazil has been mainly a transit country for cocaine and coca derivatives from Bolivia and for cannabis of Paraguayan origin. However, recently coca leaf plantations and clandestine cocaine laboratories have been found in the vast jungles of the Amazon basin. It appears that the traffickers, by taking advantage of the poor economic conditions of the Indian tribes of these areas, have encouraged them to cultivate large quantities of the Amazonian variety of coca leaf. The Brazilian narcotics police has conducted several eradication operations in the Upper Amazon region after having detected coca plantations through satellite surveillance. Although in many areas the Indians have been taught how to make coca paste for the illicit traffic, it appears that most of the coca exits the country in the form of dried leaves to be processed into coca paste or cocaine in Colombia or Peru.

In view of the potential of Brazil's drug problem, the authorities have expressed their concern about the increasing illicit traffic and their lack of resources to combat it.

Because of their geographic location, and the existence of tax havens with strict bank secrecy laws, many countries in Central America and the Caribbean, continue to be important transit staging centres for illicit traffic and for the dubious financial operations connected with such traffic.

Jamaica

Cannabis is illicitly cultivated on a large scale and the country serves as a transit point for trafficking in cocaine. The government of Jamaica has stepped up its campaign against cannabis cultivation and traffic.

AFRICA

This continent remains at great risk. Although information on the extent of drug abuse and illicit trafficking is limited, available data show that traffickers are taking advantage of the lack of adequate control and enforcement capacities in a number of African countries. Drug abuse and smuggling are gaining ground. Nationals of some African countries are now involved in trafficking heroin and other drugs. Seizures of cannabis of African origin, both within the continent and outside, have increased. Furthermore, a growing abuse of and trafficking in psychotropic substances is taking place in many countries. These trends demonstrate a deteriorating situation and require urgent attention.

Data show that only two of Africa's 51 countries require more than 1 kg annually of a limited number of psychotropic substances controlled under Schedule II of the 1971 Convention. Most countries have no requirements for these drugs.

Therefore, there can be no justification for exports of such substances to those African countries. Countries, and especially those with no requirements, are urged to prohibit the import of unwanted psychotropic substances.

North Africa

Morocco is an important centre for the illicit cultivation of cannabis which is trafficked primarily to Western Europe, often in the form of resin and oil. The current and potential dimensions of this problem require intensified action by the authorities to eradicate cultivation and interdict trafficking.

West Africa

In certain countries of West Africa, cannabis, which has hitherto grown wild, is now increasingly illicitly cultivated and becoming a cash crop. In some countries, seizures of cannabis resin, although still limited, may indicate greater emphasis on the production of this more potent product. These trends warrant close attention. Furthermore, seizure reports show that nationals of some West African countries, notably Nigeria, are serving as couriers for trafficking in heroin destined for Western Europe and North America. Experience shows that recent development of such trafficking is serious and requires special attention by the authorities.

Eastern and Southern Africa

Illicit trafficking in cannabis as well as resin and oil also occurs in parts of Eastern and Southern Africa. Moreover, this part of the continent is increasingly being used as a transit zone for illicit trafficking of opiates which originate in the Middle East or South Asia.

In a limited number of countries, cannabis abuse is combined with the consumption of khat (See page 5). Khat, which is not under international control, is produced mainly in Kenya and Ethiopia, and is sent to other countries in the sub-region and parts of the Arabian peninsula. Cooperation among the countries concerned is needed to confront the health hazards and adverse economic implications caused by the local use of khat.

Throughout the continent, the abusive consumption of psychotropic substances observed over a number of years continues to be a worrying phenomenon. The substances chiefly abused remain amphetamine, methaqualone, and secobarbital preparations. These psychotropic substances are chiefly diverted from the licit trade by means of forged documents.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000 ext 7384.

A Spirit of Responsibility

Number: 635.
Subject heading: Public relations.
Details: 16 min, color.
Synopsis: Television game-show host, Peter Marshall, outlines the four areas the Distilled Spirits Council of the United States (DISCUS) is dealing with in regards to alcohol use: research, moderation, education, and responsibility. DISCUS wants people to learn how and when to drink, and to understand the benefits of drinking in moderation. It sponsors public service announcements, distributes literature, and, in general, promotes "positive" drinking behavior.
General evaluation: Poor to very poor (1.6). Although a message of moderation may be laudable, the assessment group considered that the failure to define "moderation" may lead to confusion about safe levels of consumption. While the film discussed the contribution made by the alcohol industry to society, there was no mention made of the cost to society resulting from the use of alcohol.
Recommended use: None.

Uppers, Downers, All Arounders

Number: 636.
Subject heading: Drugs — pharmacology, drug use: etiology and epidemiology.
Details: Two parts, 30 min each, color.
Synopsis: Part one describes the effects of drugs in the general categories of downers, uppers, and hallucinogens (All Arounders). Tolerance, dependence, and addiction are illustrated. Interviews are conducted with users who relate their drug using experiences. Part two discusses in detail the actual drugs in these broad categories and how they work specifically.
General evaluation: Fair to good (3.7). This contemporary film had good information about the effects of psychoactive drugs. However, there seemed to be a great deal of repetition and the film was somewhat disjointed.
Recommended use: With a resource person, this package could benefit health professionals and general adult audiences.

Denial? Not Me

Number: 637.
Subject heading: Alcohol and the family.
Details: 30 min, color.
Synopsis: Mrs Pollard's husband appears to have a drinking problem and her "Guardian Angel," in the role of a "private eye," has been assigned to get her to a meeting. When she arrives, the only person there seems to be a cleaning lady. While she helps set up the room for the meeting, Mrs Pollard talks to the cleaning lady (who cannot understand English) and tells her all the problems she is having with her husband, all her fears, and her cover-ups. Scenes of fights and other problems caused by her husband are interspersed with her monologue. Mrs Pollard still denies that her husband has a problem but, with the help of comments made by her Guardian Angel, she begins to realize that she might need help herself.
General evaluation: Very good (5.1). This contemporary, well-produced film has a clear message. General broadcast was recommended.
Recommended use: With a resource person, could benefit health professionals and spouses of problem drinkers.

Seven, Eight, Lay Them Straight

Number: 645.
Subject heading: Cannabis.
Details: 10 min, color.
Synopsis: Several adolescent cannabis users describe why they smoke and why they intend to continue. A few young adults tell why they quit using cannabis.
General evaluation: Fair to poor (2.9). The film did not appear to have a clear message and made cannabis use somewhat attractive.
Recommended use: None.

DEPARTMENT

New Books

by RON HALL

Guidelines for Investigating Alcohol Problems and Developing Appropriate Responses

. . . by Irving Rootman and Joy Moser

These guidelines grew out of a World Health Organization project entitled "Community Response to Alcohol-Related Problems." One of its objectives was to develop approaches for coordinated research and action concerning alcohol-related problems and response to them in communities with different sociocultural settings. As the project progressed, the collaborators became aware of the potential usefulness of the approaches for other countries. This report presents a review of these approaches, as well as experience obtained in similar projects. The document is aimed primarily toward developing countries and emphasizes the process of carrying out a Community Response project. It is intended to be practical, well referenced, simple to use, and to give an idea of the time, effort, and skills needed to carry out work of this type. Chapters are devoted to needs identification and other steps in project initiation, detailed planning, information gathering, improving responses to alcohol problems, and monitoring, assessment, and adjustment of policies and programs.

(World Health Organization, 1211 Geneva 27, Switzerland, 1984. 120p. ISBN 92-4-170081-5)

Rehabilitation Approaches to Drug and Alcohol Dependence

. . . by Behrouz Shahandeh

This handbook deals with the problems of rehabilitating people who are dependent upon alcohol and other drugs, and of reintegrating them into active social and economic life. It describes the multisectoral approach to planning and organizing the relevant services, the stresses and need for the fullest possible involvement of the community. The 25 examples of rehabilitation approaches range from institutional care to self-help. The book outlines the infrastructure and administrative support services required for rehabilitation services. It deals with issues that can influence policy development of such services and outlines the importance of involving the community at all stages of planning and implementing rehabilitation programs.

(International Labour Organization, International Labour Office, CH-1211 Geneva 22, Switzerland, 1985. 91p. ISBN 92-2-100526-7)

Others books

A School Answers Back: Responding to Student Drug Use — Hawley, Richard A. American Council for Drug Education, Rockville, 1984. Acknowledging a drug problem; student drug use; training staff to recognize and respond; establishing a school-family partnership in treating drug concerns; referral to treatment; rules and discipline; prevention; parent awareness network. 145 p. American Council for Drug Education, 6193 Executive Blvd, Rockville, MD 20852. $6.75. ISBN 0-942348-14-1.

Preventing Adolescent Drug Abuse: Intervention Strategies — Glynn, Thomas J.; Leukefield, Earl G.; and Ludford, Jacqueline P. (eds). US Government Printing Office, Washington, 1983. NIDA Research Monograph No 47; role of mass media in preventing adolescent substance abuse; social-psychological approaches; health promotion; community programs; development of personal and social competence; alternatives; family-based approaches; values approach; social skill development; drug education. 261 p. National Clearinghouse for Drug Abuse Information, Rm 10-A-43. 5600 Fishers Lane, Rockville, MD 20857.

Conceptual Issues in Alcoholism and Substance Abuse — Lowinson, Joyce H, and Stimmel, Barry (eds). 1984. Physiology of opiate hedonic effects and role of opioids in motivated behavior; sequented use of clonidine and naltrexone in the treatment of opiate addicts; marijuana use among women; critical interpretation of urinary phencyclidine monitoring; solvent abuse-associated pulmonary abnormalities: multi-dimensional impact of treatment for substance abuse. 102 p. Haworth Press, 28 East 22nd St, New York, NY 10010. $19.95. ISBN 0-86656-316-4.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:

a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
¼ Page (280 lines) $250
c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation: 27,318 (Canada, 21,412; USA, 1,907; Foreign, 386; Bulk, 3,613) Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
USA & Foreign Residents: $24 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.

The Journal, 33 Russell St
Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

This publication is indexed in
BIHEP
BIBLIOGRAPHIC INDEX OF HEALTH EDUCATION PERIODICALS

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Drug Awareness for Educators — April 19-20, Toronto, Ontario. Information: Evon Essue, Clarke Institute of Psychiatry, 250 College St, Toronto, ON M5R 1R8.

Addictions Extravaganza — May 4-5, Regina, Saskatchewan. Information: Dennis Stafford, 177 North Cornwall, Regina, SK S4R 3A1.

Children of Alcoholics: By-standers at Risk — May 7, Peterborough, Ontario, May 8, Perth, Ontario. Information: Linton Heth, Peterborough Centre, Addiction Research Foundation (ARF), 223 Aylmer St N, Ste 7, Peterborough, ON K9J 3K3, or Colleen Purdy, Perth Centre, ARF, 39 Drummond St, Perth, ON K7H 2J9.

Alcohol, Other Drugs and the Law Course — May 22-24, London, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto ON M4W 2Y1.

Parent Resources Institute for Drug Education (PRIDE-CANADA INC) 1st Annual National Conference — May 30-June 1, Saskatoon, Saskatchewan. Information: Ruth Kell, convenor, PRIDE-CANADA, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

Canada Safety Council 17th Annual Conference — June 23-26, St John's, Newfoundland. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, Ontario K1G 3V4.

International Convention of Alcoholics Anonymous — July 4-7, Montreal, Quebec. Information: International Convention, Box 1995, Station D, Buffalo, New York 14210.

26th Annual Institute on Addiction Studies — July 14-19, Hamilton, Ontario. Information: Kathryn Irwin, course administrator, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer School for Addiction Studies — July 15-26, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-10, Calgary, Alberta. Information: Jan Skirrow, chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

Canadian Addictions Foundation Annual General Meeting — Aug 5, Calgary, Alberta. Information: Leona Gallinger, Canadian Addictions Foundation, Pacific Plaza, Box 702, 10909 Jasper Ave, Edmonton, AB, T5J 3M9.

United States

16th Annual Medical-Scientific Conference of the American Medical Society on Alcoholism — April 18-21, Washington, DC. Information: Louisa Macpherson, conference manager, AMSA, 12 W 21st St, 7th fl, New York, New York 10010.

National Alcoholism Forum of the National Council on Alcoholism — April 18-21, Washington, DC. Information: Angela Heather Masters, NCA, 12 W 21st St, 7th fl, New York, New York 10010.

The American Orthopsychiatric Association, Inc — 62nd Annual Meeting — April 20-24, New York, New York. Information: American Orthopsychiatric Association, 19 W 44th St, Ste 1616, New York, NY 10036.

1st Annual Pacific Regional Alcohol and Drug Education Conference: "Visions for Tomorrow — Prophets, Profits or Chaos" — April 22-24, San Diego, California. Information: Jeff Cole or Meri Beth Ring, Hillside Hospital, 1940 El Cajon Blvd, San Diego, CA 92105.

PRIDE International Parent Conference on Drugs — April 25-27, Atlanta, Georgia. Information: PRIDE, 100 Edgewood Ave, Ste 1216, Atlanta, GA 30303.

Committee on Problems of Drug Dependence 47th Annual Scientific Meeting — June 10-12, Baltimore, Maryland. Information: Dr Joseph Cochin, executive secretary, Committee on Problems of Drug Dependence, department of pharmacology, Boston University School of Medicine, 80 E Concord St, Boston, Massachusetts 02118.

16th Annual International Narcotic Research Conference — June 23-28, Seacrest, Massachusetts. Information: E. Leong Way, department of pharmacology, University of California, San Francisco, CA 94143.

36th Annual Conference of the Alcohol and Drug Problems Association of North America —"Confronting the Issues — Challenges for the 80s" — Aug 18-21, Washington, DC. Information: Eric Scharf, ADPA, 444 N Capitol St, Ste 181, Washington, DC 20001.

Abroad

Scandinavian Study Tour on Drinking and Driving and Alcohol Policy — May 24-June 8, Oslo, Stockholm, Helsinki, Copenhagen. Information: Camilla Colantonio, department of conferences, Nolte Center, 315 Pillsbury Dr SE, University of Minnesota, Minneapolis, Minnesota 55455.

10th Congress of the International Association for Accident and Traffic Medicine (IAATM) — May 27-31, Tokyo, Japan. Information: 10th Congress of the IAATM, secretariat, International Congress Service, Inc, Chikusen Bldg 5F, Nihonbashi 2-7-4, Chuo-ku, Tokyo 103, Japan.

Drinking and Driving: The Role of the Alcoholic Beverage Industry — May 27-29, Rome, Italy. Information: Frank A. Haight, Pennsylvania Transportation Institute, Pennsylvania State University, Research Bldg B, University Park, Pennsylvania 16802.

31st International Institute on the Prevention and Treatment of Alcoholism — June 2-7, Rome, Italy. Information: International Council on Alcoholism and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

International Youth Forum on Alcohol and Drugs — July 9-12, Cardiff, United Kingdom. Information: Dr Myrddin Evans, Addiction Unit, South Glamorgan Health Authority, Whitchurch Hospital, Whitcurch, Cardiff, CF4 7XB, United Kingdom.

3rd International Conference on Alcohol and Drug Abuse — Aug 11-14, Lima, Peru. Information: L. Vasquez, International Education, Peruvian College of Physicians, Wadsworth, Illinois 60083.

2nd National Drug Institute — Alcohol and Drug Use in a Changing Society — Aug 14-16, Darwin, Northern Territory, Australia. Information: chairman NDI Planning Committee, Drug and Alcohol Bureau, Northern Territory department of health, GPO Box 1701, Darwin NT 5794 Australia.

'A Native society in the process of change'

Arctic trek sheds light on FAS children

Tim Padmore reports

VANCOUVER — Kwadwo Asante, raised in shimmering equatorial sunshine, shivered in the Arctic dark.

With his rented car upended in a snow-filled ditch on the road between Teslin and Whitehorse, with winter cold seeping through his clothes, the doctor congratulated himself that he had learned to build a snare. He could rip wires from under the dashboard and, with a little luck, he thought he and his companion might dine on rabbit for breakfast.

Dr Asante's unscheduled stop on the Alaska Highway was just one incident on an odyssey through the Canadian North which is producing new insights into a preventable condition that is probably the major cause of mental retardation in the North: fetal alcohol syndrome (FAS).

New insights

A child born to a mother who drinks heavily during pregnancy is likely to suffer at least some of these signs and symptoms: low birth weight (as low as half normal); a small head with small, slanted eyes, flattened cheekbones, and thin lips; delayed development of walking and speech; and mental retardation.

The syndrome was named only a dozen years ago by two Seattle doctors; since then it has attracted a great deal of attention.

But the medical suspicions are very old. In ancient Carthage, couples were forbidden to drink on their wedding night. In 17th century Britain, epidemics of gin-drinking were accompanied by epidemics of fetal deformities, and a study of Victorian jails showed that alcoholic women had normal children when they were in prison, but deformed ones when they were free.

"This was all in our history, but somehow we lost the knowledge," says Dr Asante.

FAS authority

As it was for many doctors, the publication of the paper by Seattle researchers Smith and Jones was a revelation for Dr Asante.

He realized he had been seeing many FAS children in his own practice in the Skeena River valley in northwestern British Columbia.

He became a local authority on the subject, gave public talks in the Yukon and northern BC, and helped Health and Welfare Canada (HWC) produce the film *Pregnancy on the Rocks*.

In 1982, with the help of the Council of Yukon Indians, he obtained funding for a two-year study from the National Native Alcohol and Drug Abuse Program, which is funded by the HWC. The money totalled close to $100,000, most of it used to pay travel expenses.

In the next two years, Dr Asante and anthropologist Joyce Nelms-Matzke of Slocan, BC, who joined the project as research coordinator, eventually saw about 600 children referred by health services, schools, and individual parents. They surveyed community resources available to help handicapped children, and they carried on a parallel educational effort, speaking to community groups in every centre they visited.

Study broadened

To ease fears, the study was billed as a study of handicapped children, not FAS victims. (Broadening the study was useful as well as politic, because it provided a context for the results.) Participation was boosted also by radio ads run by the Council for Yukon Indians.

All the travelling was done in winter, because in summer families are often away from settlements, fishing and hunting.

Ms Nelms-Matzke, who has a masters degree in anthropology and has spent many years as a provincial probation officer, grew up along the Alaska Highway, travelling with her father, who was with one of the crews building the road.

She remembers that when she and Dr Asante started the first of two two-month trips through the North, their funding had still not come through.

"We did the whole thing on our credit cards, his American Express card and my Visa. I was thinking that this was perhaps going to be a very exciting but very expensive holiday."

As they struggled through their Arctic itinerary, the holiday sometimes turned dangerous as well.

The incident near Teslin left them facing night without even a car heater (the battery was dead). They were trying to keep warm by an open fire when help arrived.

Dr Asante, born in Ghana, studied at the University of BC and went to medical school in Glasgow. Returning to Canada, he studied pediatrics at Vancouver General and Montreal Children's hospitals before moving to Terrace, BC, to practice.

"I enjoy the North," he says. "It's exciting for me. Other people go to Hawaii for their holidays, and I'm going to Old Crow."

In their travels to Yukon communities, like Old Crow, the team found a society in the process of change. In some communities, usually the more isolated ones, there was little knowledge of the dangers of maternal drinking. In others, there was a growing awareness.

In one Native community, located near 100-Mile House in the BC Interior, Native efforts to combat alcoholism have been so successful there are no FAS children under the age of two or three years. This village, outside the formal study area, made a useful control group.

Leading handicap

In general, fetal alcohol syndrome was much more evident in Native communities, where it often appeared as the leading type of neurological handicap. In non-Native groups, FAS usually comes after Down's syndrome and spinal abnormalities.

Victims of the syndrome benefit from a cultural tradition of acceptance, says Ms Nelms-Matzke. "Native people are very accepting of children with difficulties. They say, 'Well, that's just the way he is.' They're not ridiculed or shunned."

If a handicapped child finds himself in difficulty, he can count on those around to come to his aid.

The tradition of acceptance doesn't mean, she adds, that mothers of afflicted children don't feel a lot of guilt and pain.

Much effort, she says, went into convincing people that the community is responsible for a lot of the problem.

"People will say, 'Oh c'mon. Come to the party, you can just have one or two.' When you live in a small community, the pressure can be tremendous. 'C'mon, be one of us. Are you too good for us?'

"We need to speak, not only to mothers, but to fathers, because often the one who pressures the mother is the father."

Social solutions

Ms Nelms-Matzke observes that some of the communities that are doing best are ones where religious groups have become involved. But the reasons seem to be social rather than spiritual.

"You may have every intention of quitting drinking, but if you go back and every social event in the community involves drinking, and you don't drink, you're excluded, and in an isolated community that's terrible."

The religious groups tend to provide the "missing link" — non-drinking social events.

Ms Nelms-Matzke says it was a humbling experience seeing the pressures that Native communities have to deal with — isolation and lack of opportunity on the reserves, the temptations of life outside, and the necessity of abandoning the social support group in order to leave. "We decided that we would probably end up being alcoholic too."

She and Dr Asante are now compiling the results of their research; they plan to turn it over to the sponsors this spring.

Photos by Nelms-Matzke

Frontier odyssey: in the more isolated communities, the health team (above) found little knowledge of the dangers

THE BACK PAGE

The Children Remembered

Part II

The centre section

Health/revenue debate restraining global anti-alcohol efforts

page 7

Mila Mulroney to meet drug chiefs?

page 2

Vol. 14 No. 5 2nd Class Mail Reg No. 2776 TORONTO, May 1, 1985

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Policy debates too often shallow

By Harvey McConnell

Besteman: no new insights

WASHINGTON — A semblance of unanimity on alcohol policy issues is vital if the field is to have a major impact on the political process, believes Karst Besteman, executive director of the Alcohol and Drug Problems Association (ADPA) of North America.

Instead, polarization is rampant, especially when it comes to control issues, Mr Besteman told The Journal.

"For reasons which aren't all apparent to me, it is hard for somebody to say that the other person has a legitimate point of view, even though they don't happen to agree with it. It is as if the other person has got to be wrong.

"If we were to be less certain of what we believe, and a little more certain of what the facts are, or what the data show, I think we could have productive and dispassionate discussion."

The differences between issues in the drug abuse and the alcohol field are glaring: "While we fight issues in the drug abuse field as vigorously, it doesn't seem to get personalized or polarized quite as badly. We in the field should not be polarized; we shouldn't argue; and we don't have to roll over and agree with everybody.

"But, we ought not to get polarized. Because, when we do, we get taken advantage of by the political process. People say, 'You can't agree on anything, why should we listen to any of you?' "

One of the most polemical issues, and one on which the ADPA has not taken a position, "and any discussion we have about it rarely produces new insights," is the role of advertising and marketing in producing "the alcohol problem" or "alcoholism."

Everyone Mr Besteman talks to has an idea on the subject, but he finds it amazing that so many have not read the literature, nor are they trying to collect literature in order to expand their knowledge.

He has been collecting as much data as possible during the past six months or so. "If there is anyone who has strong opinions, I ask them what are the two or three best papers they know on the subject and, if they've got them, could they

(See — Ad — page 2)

Most Canadian users are 'social sniffers'

Cocaine use delineated

By Betty Lou Lee

TORONTO — Adult Canadian cocaine users fall into three groups: dabblers, party-goers, and devotees.

Patricia Erickson, PhD, scientist in drug control research with the Addiction Research Foundation (ARF), applies those labels after a study of 111 Canadian users more than age 21 — the first such national study.

The dabblers are the experimenters, those who had used it once or twice in the past year, and were not very impressed by the drug, or didn't like some aspect of the experience.

The party-goers are the largest group, "the social sniffers who have used it 50 to 100 times in an irregular pattern. They basically like the effects, cocaine's stimulating properties. It's usually given to them at parties. They don't go out of their way to buy it, and they say they can take it or leave it. This is the group where demand is created — the proselytizers," Dr Erickson said.

The devotees, former and current, used regularly or in high amounts, and it appears they got stronger reactions than casual/party users to their first experiences with the drug, Dr Erickson said. A number of former devotees have quit the drug without professional help, "and they can tell us a lot about how to get off it."

Dr Erickson presented preliminary findings of the study at a cocaine seminar held by the School for Addiction Studies, a division of the ARF. Others in the research team were Reginald G. Smart, PhD, director of drug-control research; Edward M. Adlaf and Glenn F. Murray, both in the drug-control research division, ARF.

The users were recruited for the study from researchers' personal networks and an advertising campaign. They had to have used cocaine in the past three years, and been employed at least six of the past 12 months (with housewives considered employed).

"Our society has produced a generation to whom testing a new drug is as routine as sampling a new season's Beaujolais," Dr Erickson remarked.

Erickson

All those interviewed had used alcohol and cannabis, and about one-third of them were using them daily. About 95% had used hallucinogens other than LSD or PCP in the past, and 85% had used LSD and stimulants/amphetamines.

The mean age of first cocaine use was 22.2 years, and the drug was most often used at night, while with friends at a home.

"The media suggest that you need a lot of cash, like the $2,500 a week John Belushi was reported to spend, but it is given away so much, party-goers can use it quite often without ever buying, except when it is their turn. Women can use a lot and never buy," Dr Erickson said.

Among the 81 users in the study who had bought the drug, only 59 were able to estimate monthly spending: one-quarter said $100 to $300; one-tenth $50 to $100, 45% spent $1 to $50, and the rest "next to nil."

Cocaine in Canada prompts concern, not alarm

page 5

More than 90% reported they were self-confident, talkative, and energetic while taking the drug. More than 80% had experienced increased heart rate, restlessness, nervousness, dry mouth and throat, insomnia, and a congested nose.

Twenty percent had experienced an uncontrollable desire to use cocaine.

While 44% had had one or more friends arrested for possession of cocaine, only two of the subjects thought it likely they would be caught with cocaine by police. If they were charged with possession, 44% thought they would be discharged or get probation; only 14% thought they would go to jail.

Most were unfamiliar with the maximum seven-year jail term for possession, but two-thirds thought laws should be more lenient. Two-thirds didn't think their use would change with more lenient laws, but half thought their friends' consumption would change.

Advocacy key to tobacco death rate cut

By Joan Hollobon

TORONTO — Cutting death rates caused by tobacco smoke depends on active "advocacy" by professional and voluntary health agencies, as well as on firm goals and organized government programs. So concluded a University of Toronto (U of T) cancer workshop here.

The workshop dealt with priorities in research and prevention of cancers associated with tobacco use and with diet in Ontario.

Tobacco use "is the foremost preventable cause of illness, disability, and death in Ontario, and is an addiction," workshop participants agreed.

Richard C. Frecker, PhD, MD, said the term tobacco rather than smoking was used deliberately to include all forms and usages.

"We mean tobacco whether combusted, chewed, swallowed, or popped under the skin," he said.

Dr Frecker is associate professor, departments of medicine and pharmacology, and in the institute of Biomedical Engineering at the U of T as well as a physician at the Addiction Research Foundation's Clinical Institute.

The advocacy issue aroused considerable discussion. Said one physician: "Advocacy is a red flag to major agencies more concerned with maintaining their own image to raise funds."

For scientists, urging advocacy represents a marked shift in attitude and reflects their concern with the "epidemic" of tobacco-related deaths. In Dr Frecker's words, "advocacy goes beyond the provision of information, to arm-twisting, to political lobbying, to making noise in whatever is the appropriate way in a given culture without breaching all propriety."

Workshop participants were urged to make representations to governments, on a continuing basis, learning which departments are responsible for enforcing different regulations, in order to "frame your lobbying accordingly."

Some speakers were concerned agencies might lose their status as charitable organizations if they engaged in advocacy activities, but the workshop was told there are ways around this problem. Some organizations, for example, do not give tax-deductible receipts for donations directed to advocacy; others set up a separate body to implement this part of their program.

Dr Frecker said he believed some federal sustaining grants do not require recipient organizations to refrain from some advocacy-type activities.

Gar Mahood, executive director of the Non-Smokers' Rights Association here, said if real concern exists about charitable registra-

(See — Anti — page 2)

INSIDE

NEWS

Briefly...

Sudanese want beer

KHARTOUM — Sudanese protesters are hoping that the military coup which ousted president Jaafar Numeiri in April will also mean an end to liquor bans imposed here. *Reuters News Agency* reports that hundreds of Sudanese chanting "We want beer" crowded outside hotels and other public buildings. The former president poured Sudan's liquor supplies into the Nile River when he imposed Islamic law in September 1983.

Smoking hinders sex

PARIS — Tobacco manufacturers who promote smoking as sexy and macho may have to change tactics. A study suggests smoking may be one of the prime causes of impotence in middle-aged men. Researchers at the Centre d'Etudes et de Recherches de l'Impuisance here, have found that impotence is most commonly caused by poor blood circulation brought on in middle-age by smoking and a diet high in fat. In a report in *The Lancet*, the researchers say men whose impotence is caused by poor circulation (eight out of 10 cases) are twice as likely to be smokers and 10 times as likely to have high blood cholesterol as other men not suffering from the affliction.

Workaholics' hearts

ROCHESTER, NY — Workaholics — those achievement-oriented, hard-driven people labelled as type A personalities — may not be at any higher risk of death following heart attack than their calmer colleagues. In a study conducted here at the University of Rochester, researchers quashed earlier notions that personality type may be a good predictor of survival following heart attack. No significant differences were found in death rates of 519 heart-attack patients (two-thirds type A and one-third type B) after one-to-three-years follow-up, reports *The Toronto Star*.

Script thefts foiled

LONDON — The Royal College of General Practitioners here would like to foil prescription pad thieves by instituting special forms for the prescribing of controlled drugs. The forms, says the College, should be distinctly different from regular script forms and issued to doctors in limited numbers. "This would make the stealing of doctors' prescriptions much less attractive for addicts," the College told a Commons inquiry into drug abuse. At the same time, says a report in *Doctor*, GPs are calling for more training in all aspects of drug addiction at both the undergraduate and post-graduate levels.

Wine bargain

TORONTO — An effort by the Ontario government to clear a stockpile of partly-processed grapes will mean bargain prices for drinkers of Ontario wines. Prices were slashed at Liquor Control Board outlets in April on all provincial wine products, and will stay down until an undisclosed portion of the 20,000 tonne stockpile has been reduced. The federal government purchased the grapes last year after Ontario growers were unable to sell the surplus to wineries, reports *The Toronto Star*.

Willpower still their chief aid

Smokers hearing but not believing

By Alan Massam

LONDON — There has been a 7% increase in the number of 18 to 24 year olds smoking in Britain.

A National Opinion Polls (NOP) market research survey on attitudes to smoking and health, undertaken in December 1984, on behalf of Lundbeck Ltd, distributors of Nicorette (nicotine gum), has shown both positive and negative trends in smoking habits.

The survey, which was a repeat of a 1981 study, sought to compare trends in attitudes to smoking and health, and changes in smoking habits. It found that compared with 1981:

- Women and young people are smoking fewer cigarettes.
- There has been some reduction in men smoking 16 to 20 cigarettes a day, although the proportion of men smoking more than 20 a day has risen slightly.
- One-quarter of smokers tried to stop smoking three or more times — up from 16% in 1981.
- Nearly one-fifth of male smokers have tried to stop more than four times.
- Eighty-nine percent of smokers rely on will-power alone to stop smoking.

The survey found that family physicians are making a difference in smoking trends, but more could still be done to help patients. Physicians are giving more people advice about not smoking, even when they consult for some reason other than smoking-related conditions — especially in the 35-to-49 years age group and among women.

More nicotine gum is being prescribed, and is now the method most frequently used to give up smoking, after will-power alone.

Women and smoking:

- The number of female smokers was the same as in 1981, but they tended to be smoking fewer cigarettes.

Younger smokers:

- Forty-two percent of 18 to 24 year olds in 1984 were smokers, 5% more than in 1981.
- Of these youngsters, 61% had tried to stop, although these attempts seemed to be largely unsuccessful. This highlighted the importance of campaigns designed to educate people not to start smoking.
- Fewer 25 to 34 year olds were smoking in 1984 — a decrease of 4%.

Is the health message getting across?

- Only 45% of current and ex-smokers expressed worry about the ill-effects of smoking on their health — an 8% increase since 1981. This is surprising as more than 90% of smokers and ex-smokers are aware of the link between lung cancer and smoking, and 75% realize that smoking can affect the heart. Thus, the figures suggest that many smokers still believe "it will never happen to me."

The increasing role of the GP in giving advice and educating patients, and, where appropriate, prescribing nicotine gum can only help to improve the situation.

Among the young: campaigns largely unsuccessful

Anti-smokers aim to 'make noise'

(from page 1)

tion "let that be the very first advocacy issue they address."

Workshop participants drew up five recommendations:

- The Ontario Ministry of Health (MoH), in collaboration with local health agencies, develop goals and objectives and set targets for tobacco control in Ontario;
- Guidelines be developed for model programs for prevention of tobacco use and for "protection from involuntary exposure to tobacco smoke;"
- The Ontario MoH designate tobacco control as a mandatory health program under the Health Protection and Promotion Act, providing 100% of the funds for implementation by local health agencies;
- The Ontario MoH finance demonstration projects to advance the development of "effective, community-based, tobacco-control programs," providing adequate funds for long-term evaluation; and,
- The major voluntary and professional health agencies "devote significant proportions of their resources and budgets to advocacy activities directed to changing public policy to effectively control tobacco."

The recommendation that Ontario should have targets for tobacco control follows the current policy of the United States National Cancer Institute (NCI).

Philip Cole, professor of epidemiology at the University of Alabama School of Public Health, Birmingham, said the US national goal is to cut cancer deaths by 50% by the year 2000. He said this goal is ambitious, but if the program proves only partially successful, it will still be an achievement.

The NCI believes prevention can cut deaths 25%; improve detection, 12%; and better treatment, another 13%, not by new "breakthroughs," but simply by making the best of current cancer care available to 95% of patients.

Mary Jane Ashley, MD, professor and chairman, department of preventive medicine and biostatistics, U of T, told **The Journal** later that many Canadians are concerned that Canada's national government has not taken steps to set goals and objectives.

The primary value of doing this would be "to get us working towards specific ends. It would target energy, programs, funding, and attention to a specific goal. Where there are a lot of diffuse things going on now, this would help to bring it all together," she said.

Cigarette smoking has to become unacceptable, like spitting in public, Dr Cole said. But, Dr A. B. Miller, director of the National Cancer Institute of Canada's epidemiology unit at U of T, said such a major change in public behavior would need "upper-level political input."

Protection of the "passive smoker" was a major concern, since a number of studies have shown increased death rates among non-smokers exposed to tobacco smoke.

Neil E. Collishaw, chief of policy analysis, Bureau of Tobacco Control and Biometrics, Health and Welfare Canada, said tobacco smoke is related to the 5,000 lung cancer deaths among non-smokers in the US every year.

Mr Collishaw quoted studies in several countries that report increased cancer deaths among exposed non-smokers.

Among smokers, tobacco is responsible for 20% of all deaths in people between the ages of 35 and 84 years — 25,000 deaths among smokers in Canada every year, 11,000 to 12,000 from cancer.

Mr Collishaw doubts a "safe smoke" will ever be found, but tobacco smoke research can be useful in providing information on the risks: for example, tobacco smoke is a complex mixture of more than 3,800 chemicals that include at least 60 known or suspected human carcinogens, at least 51 in the particulate phase and nine in the gas phase.

Mr Collishaw said that the results of switching to low-tar cigarettes vary widely because of different smoking habits: between one-quarter of a litre and a litre of smoke can be inhaled from a single cigarette, so the amount of tar, nicotine, carbon monoxide, and other constituents carried in the smoke also can vary widely.

None of this information is communicated by standard tar yields.

Ad policies need facts

(from page 1)

send me copies." So far, the stack on his desk is about one-foot deep and rising.

"Frankly, I don't know what the answer is, and I just want to know for myself what are the facts. Policy doesn't have to follow the facts. I learned a long time ago policy is not a function of research information. But to me, not to know what the facts are, and to discuss policy, is not productive."

Professionals need to be rooted in facts, and the advertising and alcohol issue is one in which the facts are not clear. Some claim children are widely influenced by advertising, while others claim if anything is done to change the present situation, it will only be a symbolic act.

Advertisers will claim they can give their customers product identification and market connotation. However, many will admit they are not sure what advertising really does; but everyone goes out and spends money on it in fear that if they don't, their position in the market will deteriorate.

The electronic media seems to be the nemesis, Mr Besteman believes. Yet, if one looked at the tobacco industry, where cigarette advertising has not appeared on television for decades (in the US), "companies seem to be doing rather well in getting new customers and seem to be marketing very well in the print media."

The fact he remains uncertain, Mr Besteman observes, means that those who are adamantly against alcohol beverage advertising are angry because he won't try to commit the ADPA in that direction, while colleagues in the beverage industry, and advertising and communications industries, are nervous because he won't make a clear stand on the other side. It isn't an easy task trying to stay in the pragmatic middle.

Mila Mulroney goes to drug conference

TORONTO — Mila Mulroney is considering espousing as her "cause" for 1986 the fight against drug abuse.

Before the Canadian Prime Minister's wife left Ottawa to attend the PRIDE International Conference on Drugs in Atlanta, her executive assistant, Bonnie Brownlee, told The Journal that Mrs Mulroney had received requests for interviews on drug abuse from across Canada.

She said Mrs Mulroney was not granting interviews now, but is considering holding a conference after the birth of her fourth child in the fall.

Representatives from Canadian drug programs could then "sit down and tell Mrs Mulroney what their program is and who they are," enabling her to decide if she wishes "to take the drug program as her cause in 86," Ms Brownlee said.

Mrs Mulroney is one of 17 wives of national leaders invited to the meeting by the wife of the president of the United States.

NEWS

Role of genetics probed in drinking behaviors

By Harvey McConnell

KANSAS CITY — Genetics plays a part in drinking behavior, but an ongoing study of twins, non-twin siblings, and adoptees has already produced some surprising results.

The five-year study being carried out by the Institute for Behavioral Genetics at the University of Colorado involves both identical and fraternal twins, pairs of adoptees raised in the same home but not genetically related, and non-twin sibling pairs.

One of the principal investigators has been William Gabrielli, PhD, who is now at the department of psychiatry at the University of Kansas, College of Health Sciences here, and who published two recent reports with colleague Robert Plomin, PhD (*The Journal of Mental and Nervous Diseases*, Vol 175, No 9, 1985; *Journal of Studies on Alcohol*, Vol 46, No 1, 1985).

Dr Gabrielli, commenting on the study, points out that the subjects are not alcoholic, and he and colleagues are looking at usual behavior patterns, not pathological alcohol behavior.

In the first study, they selected 46 identical twin pairs; 44 fraternal twin pairs; 37 non-twin sibling pairs, and 46 pairs of unrelated individuals reared together. They were all given the Colorado Alcohol Behavior questionnaire, which has been developed to assess amount, frequency, and rate of alcohol consumption; behavior sensitivity and tolerance to alcohol; reason for drinking; and drinking location.

Dr Gabrielli told **The Journal** they have found what appear to be some genetic influences for drinking behavior both in the rate and quantity of alcohol consumption. "We have found that most of the genetic influences, however, are not simple genetic influences; they are probably related to a combination of interactions of several genetic influences."

They found that the environmental settings and experiences which relate to drinking appear to be influences that are not shared. They are not the kind of influences brothers and sisters usually have in common, but broader influences for each, such as relations to friends, school, or other influences which do not tend to be clustered within a family. Dr Gabrielli said heavy drinking and maximum amounts show the least evidence for a genetic influence.

In the second study, which used a subset of 54 pairs of twins and adoptees, they measured the individual difference in anticipation of alcohol sensitivity. They found what appeared to be a genetic influence for the anticipated sensitivity to physical symptoms and coordination but not for other symptoms, such as drinking and thinking problems, moods, or driving ability.

"We have also discovered that those people who drink more on average are not very good at predicting (alcohol sensitivity), particularly when related to the group of characteristics related to mood, drinking problems, and driving ability."

Some people are not very good at anticipating how much alcohol will affect them, and people with a history of heavier drinking tend to be most likely to underestimate the effects.

Script renewals need MDs' okay

By Maureen Brosnahan

WINNIPEG — Manitoba pharmacists have been warned to speak directly to doctors when filling prescriptions after a pharmacist here was found guilty of filling 755 prescriptions to 48 fictitious patients.

The pharmacist accepted the prescription orders from a physician's receptionist, who was also charged in the case, instead of speaking directly to the doctor, said Stewart Wilcox, registrar of the Manitoba Pharmaceutical Association.

The 755 prescriptions involved an estimated 22,650 pills of Ionamin 30 (phentermin resin), an amphetamine that is also used for weight control, Mr Wilcox told **The Journal**.

He said the pharmacist had been fooled by the receptionist, whom she had come to know, and the oral forgeries had been filled during a five-year period.

It's the first time a pharmacist has ever been charged in such a case in the province, said Rick Brown, chief of the Bureau of Dangerous Drugs in Manitoba.

Mr Wilcox said the receptionist had set up a sophisticated system using 48 fictitious names and phoned in renewals for the prescriptions on a monthly basis.

He said although the pharmacist appeared to be an unwitting victim in the scam, the association felt it was necessary to charge and fine her $1,250 under the federal Food and Drugs Act.

That Act demands that a pharmacist speak directly to the doctor to confirm or renew prescriptions for controlled drugs such as Ionamin 30.

The incident came to light last year after a drug inspector noticed that the pharmacy was filling a large number of prescriptions for the amphetamine drug which is not commonly used.

Mr Wilcox: "This particular case was very sad. She (the pharmacist) got caught in a system . . . . It's the first time we've had a case resulting from this type of behavior."

However, he added it's likely the same method has been used by others to obtain prescription drugs illegally.

Mr Brown said the case is unusual because of the large amount of the drug involved, but the basic offence "has happened before."

"This is a very safe scam," Mr Wilcox said. "It can happen."

He said the case should serve as a warning to other pharmacists to be careful about filling prescriptions by phone.

But, Mr Wilcox added, many pharmacists find it difficult to comply with the law because some doctors won't cooperate and refuse to come to the phone or return a pharmacist's call.

Instead, he said, some threaten to deal with another pharmacy.

"We resent the fact that the doctors say they are too busy," he said. "Pharmacists have seen this as a problem for a long time. The doctors just don't see it as a problem.

". . . We warn the pharmacists that if they do this, they must be ready to face the consequences."

James Morison, registrar of the Colleges of Physicians and Surgeons of Manitoba, conceded that relations between the two groups can be a problem.

Dr Morison said he has sent a notice to all doctors in the province urging them to cooperate with pharmacists.

But, Mr Wilcox said, the burden still rests with the pharmacist, who is ultimately responsible under the law.

Marijuana favored by most young New Zealand doctors

By Tony Garnier

WELLINGTON, NZ — A survey showing that 76% of New Zealand's young doctors have smoked marijuana has upset the medical association here.

A survey of 80 house-surgeons and registrars who attended a medical conference in Christchurch recently, showed that more than three-quarters had tried marijuana.

Fifty-three percent of the smokers admitted using it several times during the past year. And several said they used the drug regularly, smoking "joints" weekly.

A survey organizer, John Aiken, MD, said most of those surveyed were in their 20s and 30s.

"I wasn't very surprised by the survey results. I would say they would be a reasonable indication of New Zealand house-surgeons' and registrars' use of marijuana, and accurate to within 5%," he said.

Dr Aiken said there was "clear consensus" among conference delegates that marijuana should be decriminalized.

However, the chairman of the NZ Medical Association, Dean Williams, MD, said he was surprised and distressed by the survey result.

He said he was upset that so many doctors had tried marijuana, and added that it was illegal, irrespective of the arguments for and against the drug.

Doctors have access to drugs through their work, "and I am concerned they could break the law again and take drugs from hospitals or write illegal prescriptions."

Dr Williams also expressed concern about the public's reaction to young doctors smoking marijuana, saying it wouldn't strengthen the public's respect for the profession.

Pot-smoking patients pose problem in NZ

By Pat McCarthy

AUCKLAND, NZ — Pot smoking by hospital patients is creating an ethical dilemma for nurses in New Zealand.

The Nurses Society says it has been approached four times in recent months by nurses asking for advice on how to deal with patients who smoke cannabis openly.

The society's national director, David Wills, says nurses feel an obligation to report these patients to the police, but this feeling conflicts with the medical ethic of protecting patients.

Drug avatar's teachings find final resting place

By Wayne Howell

I made a peculiar discovery in a bookstore the other day: I found the collected works of Hunter Thompson arrayed under the heading "SOCIOLOGY." There they were: *Hell's Angels, Fear and Loathing in Las Vegas, Fear and Loathing on the Campaign Trail 1972, The Great Shark Hunt*, and *The Curse of Lono*.

How ignominious, I thought — the "King of gonzo," the "quintessential outlaw journalist," the man Tom Wolfe described as "a scorching epochal sensation," the man William F. Buckley reluctantly admitted "elicits the same kind of admiration one would feel for a streaker at Queen Victoria's funeral," consigned by some compulsive bibliopole to the drab section devoted to "the science concerned with the origin and evolution of society and social phenomena."

This discovery lead to a question: was Thompson filed here because he was considered to be a sociologist of a sort, or was he filed here because he was considered a "social phenomenon," an appropriate subject for study by sociologists? My heart says the former, but somewhat reluctantly — after a reading of Thompson's latest opus (*The Curse of Lono*) — my head says the latter. The book is such unadulterated, paranoid, sick drivel that it doesn't make me wonder about the state of Thompson's mind — it makes me wonder about my own. How could I ever have imagined that Thompson counted for something, that he had something special to say?

Well, for starters, his first book — the one on the Hell's Angels — was a fine piece of work. I read it years ago, when I didn't know who Hunter Thompson was, or who he was to become. The book was neither self-indulgent nor self-promoting. It was, in fact, a brilliant "sociological" study of California's outlaw bikers.

Then I read *Fear and Loathing on the Campaign Trail 1972* and found it weird, but wonderful. Weird and wonderful enough that I backtracked and read *Fear and Loathing in Las Vegas*, the book that had preceded it. I had trouble with that book — the paranoia, the drug consumption, the undertones of violence — but convinced myself that the book was a significant metaphor about society in the United States, or, to be more fair and more specific, the part of US society that had produced a city like Las Vegas.

By the time I had finished reading *Fear and Loathing in Las Vegas* in the mid-1970s, the Hunter Thompson spin-off industry had moved into high gear. Hunter Thompson had become "Uncle Duke" in Gary Trudeau's popular cartoon series *Doonesbury* and had inspired a Bill Murray film (*Where The Buffalo Roam*). Thompson had become, as the saying goes, a legend in his own time. And I was still a "fan" of a sort — enough of a fan that I was willing to plunk down $22.50 for the hardcover version of *The Great Shark Hunt*, a cynical collection of pre-fame journalism and post-fame gibberish; and willing to plunk down $3.50 for an issue of *Playboy* (I averted my eyes from the pictorials of course) that promised an excerpt from Thompson's latest, *The Curse of Lono*.

Perhaps it is allegorical that my penultimate hit of Thompson should come from the pages of *Playboy* (I say penultimate since my last hit was the full text of *The Curse of Lono* from the "sociology" section of Classic book store) because, in a way, Hunter Thompson and *Playboy* publisher Hugh Hefner have a lot in common. Both have influenced mid-20th century US life — one as the avatar of sex, the other as the avatar of mind-bending drugs. And both are, to a certain extent, self-created caricatures, the one a shrewd businessman masquerading as a sybarite, the other an insightful journalist masquerading as a demon drug freak. Unfortunately, in the case of Hunter Thompson, it would appear that he has become what he has spent so much time pretending to be.

A reading of *The Curse of Lono* convinces one of two things. The first is peripheral: Ralph Steadman, the British caricaturist who has been paired with Thompson since the good old Rolling Stone days, may well be an illustrator of genius, a mid-century version of George Grosz. The second is more to the point: Hunter Thompson has become pathetic. His prose now reeks of paranoia and pointlessness, and what used to dazzle now depresses. He has become the literary equivalent of the carnival "geek" that bites the heads off chickens for the amusement of the crowd. Whether this is due to the drugs he is alleged to have ingested, or due to the drugs he actually has ingested is a moot point — equivalent to speculating about the causes of Hugh Hefner's recent stroke. In any event, someone more prescient than I has seen fit to file the Thompson journalistic *oeuvre* under "SOCIOLOGY," and I can no longer argue with that. Indeed, I look forward to the day when the literary works of William S. Burroughs get the same treatment.

NEWS

RESEARCH UPDATE

Acetaminophen danger for alcoholics

Excessive ingestion of acetaminophen has the potential to cause severe liver damage in alcoholics, a Chicago study has warned. Three physicians from two medical centres in Chicago presented three cases of men with histories of alcohol abuse who suffered severe toxicity from excessive use of acetaminophen. Prior to admission to hospital, the men said they had taken a number of regular and extra-strength acetaminophen tablets for pain, but they all denied taking a single massive dose or having any suicidal intent. All three patients suffered liver damage and two had renal failure. One patient, who was also a drug abuser, died following cardiac and respiratory arrest. The researchers said enhanced toxicity of acetaminophen in alcoholics can be expected for several reasons: the poor diet of alcoholics can enhance the toxicity of the drug; pre-existing liver disease can increase the risk of injury; and alcoholics may be more likely to exceed recommended doses of an over-the-counter drug because they cannot recall the time of the last dose. The researchers said that while low doses of acetaminophen should be safe, even in the presence of liver disease, the maximum dose of extra strength tablets may cause toxicity in high-risk individuals. They recommended that a warning of the potential of excessive doses should be included with the drug.

Journal of Clinical Gastroenterology, Feb 1985, v.7:55-59

Caffeine and panic disorders

The first direct evidence that patients who are subject to panic attacks are more susceptible to the anxiogenic effects of caffeine has been provided by researchers at Yale University. In an extensive clinical study, Dennis Charney, MD, George Heninger, MD, and Peter Jatlow, MD, compared the effects of an oral administration of caffeine (10 milligrams per kilogram) on 17 healthy subjects and 21 patients diagnosed with agoraphobia with panic attacks or panic disorders. Tests showed that caffeine produced significantly greater increases in subjective anxiety, nervousness, fear, nausea, palpitations, restlessness, and tremors in the patients compared with the healthy controls. These symptoms were significantly correlated with plasma caffeine levels in the patients but not the controls. Seventy-one percent of patients reported that the behavioral effects of caffeine were similar to those experienced during panic attacks. The researchers said the findings suggest patients with anxiety disorders would be wise to avoid caffeine-containing foods and beverages. They also said the study may provide data relevant to helping gain an understanding of the neurobiology of panic anxiety.

Archives of General Psychiatry, March 1985, v.42:233-243

Alcohol abuse alters bone chemistry

A reduction of bone thickness and volume due to chronic alcohol abuse has been detailed by a pair of South African researchers. Christine Schnitzler, MD, and L. Solomon, MD, of the MRC Bone Metabolism Research Group and department of orthopedic surgery, University of Witwatersrand and Johannesburg Hospital, studied the bone morphology of 19 moderate or heavy drinkers who presented with severe osteoporosis and fractures or other bone problems and compared these findings with 43 non-drinkers either with or without osteoporosis. Translilia bone biopsy specimens were examined to assess the trabecular bone volume and thickness, bone resorption and formation, and other elements of bone morphology. Significant differences were seen in the drinking group compared to controls, including diminished trabecular bone volume and thickness, lower bone formation, and increased bone resorption. The researchers speculated the toxic effect of alcohol may break down the close association between bone resorption and bone formation leading to accelerated bone loss. They concluded that "the addition of alcohol abuse to age-related bone loss may, with the passage of time, be expected to lead to a more severe form of osteoporosis" than that found in fracture patients who were not abusing alcohol.

South African Medical Journal, Nov 10, 1984, v.66:730-734

Nicotine aids obstructive sleep apnea

Nicotine has been shown to be of some value in the treatment of obstructive sleep apnea, an illness which causes a person to stop breathing periodically during sleep. Because of the ability of nicotine to stimulate upper airway muscle activity, physicians from the department of medicine, Case Western Reserve University, Cleveland, tested the effect of nicotine with eight male patients with sleep apnea syndrome. Measurements of various parameters during sleep were taken on the patients both without treatment and after chewing 2 milligrams of nicotine in gum at hourly intervals for five hours before testing, with an additional 4 mg of nicotine given 30 minutes prior to sleep recording. The researchers found that nicotine significantly reduced the total number of apneic episodes (episodes of breathing cessation) during both the first and second hours of sleep, while not affecting other measures such as heart rate, sleep structure, or length. But, because of its transient effects, the researchers concluded "nicotine in its present form obviously is not a particularly good therapeutic agent in obstructive sleep apnea." The research does suggest, however, that drugs currently being tested, which are long-lasting and do stimulate upper airway dilating muscles without interfering with sleep behavior, would be ideal for treatment of this illness.

Chest, Jan 1985, v.87:11-17

Pat Rich

Drug cabinet contents guessed at, forgotten by many elderly patients

CARMEL, Cal — A significant number of elderly patients fail to list all medications they are taking when questioned at an initial visit to a doctor's office, a study conducted in San Diego, Cal, has reported.

"Drug-related problems are common in elderly patients and drug histories often difficult to acquire," researchers at the department of medicine, University of California, said.

Their study to test the hypothesis that more drugs would be reported during a home visit than in a drug history taken in a doctor's office was presented here recently at the annual meeting of the western section of the American Federation for Clinical Research.

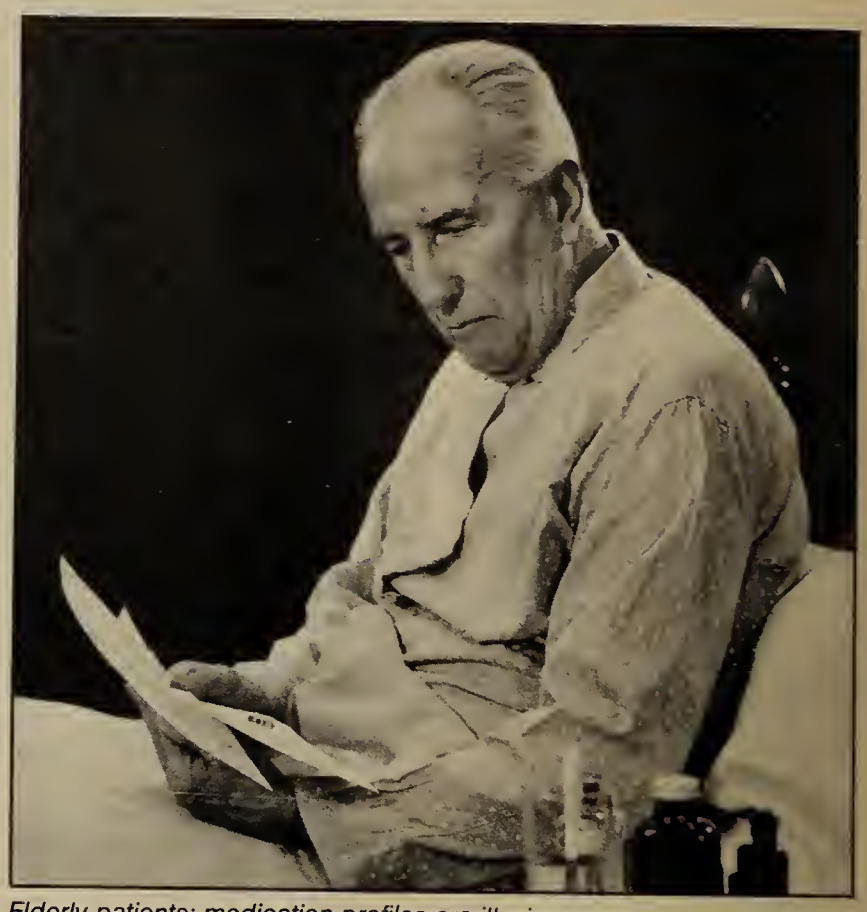
The records of 139 patients seen in an out-patient geriatric evaluation clinic from January 1983 to September 1984 were reviewed when patients were seen first by an internist and were then visited at home by a nurse practitioner.

The ages of the patients ranged from 63 to 81 years with the mean age being 72. Sixty-five percent of the patients were women.

According to the information gathered, the average patient was regularly taking a mean of 2.18 drugs or medications.

But, a comparison of the information gathered at the medical clinic and at the patients' homes showed that the same medication list was given by the patient in only 38% of cases.

In a similar percentage of cases, the office visits listed more drugs than were found at the home visit.



Elderly patients: medication profiles are illusive

A total of 103 drugs were listed in the 51 cases that were not reported during the home visit.

In 24% of cases, the home visit listed drugs that were not noted during the initial office visit. In these cases, 61 medications were not reported at the office visit.

The categories of drugs most frequently reported in only one of the two interviews with the patient were non-steroidal anti-inflammatory agents, antipsychotic agents, diuretics and antimuscarinic agents.

The only category of drug consistently found in the home visit and not reported at the office visit was megavitamins.

The finding that neither the office visit nor home visit is reliable in producing a complete medication profile has "important implications" for studies of drug use among the elderly, the study concluded.

Drinking-driving teens overconfident

CARMEL, Cal — An analysis of dangerous-driving situations among a group of Seattle teenagers has revealed the large part played by drinking.

Jim Farrow, MD, of the division of adolescent medicine, University of Washington, Seattle, commented on the analysis of the 662 incidents reported by 16 to 19 year olds, at the annual meeting here of the Western Society for Pediatric Research.

The 192 subjects, who had all been driving for at least six months and had taken a driver education course, were asked confidentially to report any dangerous-driving situations they were involved in as either driver or passenger. Such a situation was defined for them as being: "If a cop had been there, you probably would have been stopped." All reported incidents were independently reviewed for accuracy.

Of the total number of incidents reported, 404 (61%) involved alcohol or other drug use. The dangerous-driving situations most commonly reported by the total group were driving while under the influence or immediately after alcohol or other drug use, speeding, and reckless driving.

Dr Farrow said that while 63% of the teenagers who reported incidents involving intoxicants considered the driver was moderately to very intoxicated during the incident, 20% said they had consumed more than 10 drinks prior to the incident.

However, while beer was the most common intoxicant involved, 87.5% of the respondents thought they were not impaired after drinking beer.

Marijuana was involved in 126 reports, Dr Farrow said, and alcohol and marijuana combined were also reported in a number of incidents.

He noted that the "vast majority of incidents went without consequence."

While 4.5% of the total number of incidents resulted in a warning or citation being issued, none of these was for driving while impaired, he said.

Although 47% of the subjects said they were frightened during the driving incident, 68% of the teenagers who were involved as passengers (almost half the sample) said they would ride again with the same driver unconditionally.

Analysis of the survey results also showed that the majority of subjects tended to drive dangerously in the family car and not in their own, and the majority of incidents occurred while passengers were in the car, and late at night.

Dr Farrow said subjects typically said they could undertake dangerous driving activities without serious consequences.

"The idea that 'this is not going to happen to me' shows up time and time again," he said.

A number of potential recommendations could be made from the survey results, he said, including placing a curfew on young drivers, limiting the number of passengers they could have, encouraging safe driving programs, and modifying drivers' education programs to include an analysis of what precipitates dangerous driving situations.

Clonidine could reduce cravings of heavy smokers

NEW YORK CITY — Clonidine may help smokers kick the habit, suggests a study here on the effects of the drug on cravings of heavy cigarette smokers.

Researchers at the New York State Psychiatric Institute say the findings of the double-blind, cross-over study also provide new evidence of a noradrenergic role in cravings and addiction.

Fifteen volunteer, heavy smokers (30 or more a day) were given either clonidine, alprazolam, or placebo in two doses, 90 minutes apart. Physiologic and psychologic tests showed that clonidine reduced cravings significantly more than either alprazolam or placebo.

Other research has shown that clonidine suppresses withdrawal symptoms in opiate and alcohol addiction.

Mark Gold, MD, said the study suggests a physiologic basis for relapse in cigarette smokers.

"I think this is a major report because it expands our notion of panic withdrawal states to include an important, widely abused substance — tobacco," Dr Gold told *Medical World News*.

Richard Gilbert returns next month.

FOCUS ON COCAINE

Experts voice concern, not alarm

Canada's cocaine problem small but growing

Betty Lou Lee reports from the School for Addiction Studies Cocaine seminar

TORONTO — Cocaine has grabbed the media spotlight as *the* illicit drug of the 1980s. But, put into the perspective of the entire drug abuse scene, what impact is it having on Canadians?

A panel of legal, treatment, and research specialists was asked for succinct answers to two questions at a seminar on cocaine held by the School for Addiction Studies here, a division of the Addiction Research Foundation (ARF): Does Canada have a problem with cocaine? What should be done about cocaine?

Their answers reflected concern, rather than alarm, and a vagueness about any plans of action.

* * *

Reginald G. Smart, PhD, director, drug control research, Social and Biological Studies Division, ARF:

"Canada has a small but growing problem. I believe it will come to Canada to a greater extent, but not to the United States levels, where 20% to 30% of young adults have tried it. We shouldn't be complacent, but it isn't the problem that alcohol, tobacco, and cannabis are. Not all cocaine use is harmful.

"We aren't doing such a bad job now. I would like to see better monitoring studies for trends, especially in adults, and continued efforts to decrease demand and supply, but no drastic change from what we're doing now."

On a more whimsical note, Dr Smart said: "One way to reduce demand is to keep people poor. There is a close association between per capita consumption of alcohol and real income. Cocaine came along when real incomes were declining, or staying even, in the late 1970s. If the economic situation improves, interest in cocaine and alcohol may increase. But the government is making an effort to keep people poor."

Superintendent Rodney T. Stamler, officer in charge, Drug Enforcement Branch, Royal Canadian Mounted Police, Ottawa:

"From a law enforcement point of view, it's a problem with organized crime being involved and reaping considerable benefit, with safety on the streets and more violence as criminal organizations become more powerful. I estimate we have 10% of the US problem. We see the same problems in Europe and the rest of developed countries; we're no different.

"The supply end can't be dealt with at this time: there are too many drugs from too many environments. We have to concentrate on the only thing in our power, reducing demand. Education and changing attitudes may sound simplistic, but we have to try."

Ihor N. Malyniwsky, chief of information services, Bureau of Dangerous Drugs, Health and Welfare Canada:

"I think it has been a problem for some time, and is escalating. . . . Control will require a strategy. The supply side has political and economic factors; the demand side requires education and better treatment facilities."

Rebecca Shamai, Toronto lawyer:

"The problem stems more from it being made illegal, than from the level of use: the illegal networks, violence in distribution, and the glamor given to using it. . . . But, I wouldn't dismiss personal problems from abuse. (The solution lies) in decreasing demand through education, and eradication of the supply."

Smart

Stamler

Panelists agree: there's relatively low-level cocaine use in Canada today.

Malyniwsky

Martin

Fehr

Erickson

Garth Martin, head of socio-behavioral treatment services, Clinical Institute, ARF:

"It's an emerging problem that's likely to get worse before it gets better. A growing number are presenting with cocaine as the principal drug of abuse. For those seeking admission to the Clinical Institute last month, 5% named it as their principal drug, and another 5% as their second. That represents 250 people a year.

"There has to be more access to treatment services. Some don't identify cocaine users as being within their service, and I hope they will broaden their horizons.

"If you get rid of the supply, you will decrease demand. We saw that in the speed era of the early 1970s; use dropped when the supply diminished. The more it is available, the more we see in treatment."

Kevin Fehr, PhD, science specialist, School for Addiction Studies, ARF:

"The problem to society depends on how many users and how toxic the drug is. It's small here, relative to the US. With the publicity surrounding incidents like Richard Pryor's burns from free-basing, maybe the adverse publicity got here before the drug.

"I'll not be simplistic and call for public education, but some people are still misinformed about cocaine because its toxicity wasn't recognized in the 1970s."

Patricia Erikson, PhD, scientist, drug control research, Social and Biological Studies Division, ARF:

She agreed with the other scientists on the relatively low level of use.

"We have to keep an open mind on what will be effective and look to other substances. During prohibition, all the demand didn't come from alcoholics, some people just wanted to have a good time. But with heroin, the demand comes from those dependent on it. In Canada, it's time for strategies."

Don't be intimidated treatment pros warned

TORONTO — Cocaine abusers can do just as well in existing drug treatment programs as those abusing other drugs, but some therapists appear to be intimidated by the mythology that surrounds cocaine, says Garth Martin, head of socio-behavioral treatment services at the ARF Clinical Institute here.

"We hear phenomenal stories that cocaine gives you energy and confidence, makes you feel better about yourself, prolongs erections, and sustains orgasms. Against this, are we going to suggest that you try bowling?

"But we shouldn't be psyched out or intimidated. There is reason to be optimistic. The programs we have are as effective with cocaine as they are with other drugs," Mr Martin said.

A study done at the ARF in the early 1980s showed no significant differences in one-year treatment outcomes between a group of 62 drug abusers who were not using cocaine, and another 57 who were. Treatment was considered successful for 24% and 26% respectively. Thirty-three percent of the cocaine users and 42% of the others were significantly improved, while 40% of the cocaine group and 34% of the others were unimproved.

Even a small group of 11 heavy cocaine users "have done at least as well" as other abusers, with an 18% unimproved rate.

Mr Martin found few significant differences in profiles of the two groups of abusers: they tended to be young, single males with similar education and employment histories. Net income was higher for the cocaine group, particularly for heavy users.

There was a marked difference in their drug use patterns. Those who used cocaine used three times as many stimulants in the past year. Of 10 classes of drugs, such as alcohol, solvents, and tranquillizers, the cocaine users had taken 6.3 in the previous 10 months, compared to 5.7 for the other group.

Mr Martin said that in 1979, only 1% of those admitted to the Institute listed cocaine as one of their drugs. That grew to 5% in 1982, "and, for 25% of those now presenting, cocaine is the drug, or one of the drugs complained of."

Dependence patterns similar to amphetamine abuse: Fehr

TORONTO — No sharp distinction can be made between physical and psychological dependence on cocaine, says Kevin Fehr, PhD, an ARF scientist.

"For a long time, it was said there was no dependence on cocaine. Then it was said there might be psychological, but not physical dependence.

"But in the crash phase, after using it for several days, you lose the distinction between mind and body. Depression in the crash phase is one of the main reasons people continue to use it."

Dr Fehr said dependence on cocaine is similar to amphetamine dependence, and most of the behavioral effects are the same. In a double-blind experiment, experienced stimulant users couldn't always distinguish the effects of cocaine from those of amphetamine until the short-lived actions of the former began to wear off.

The mild psychological effects are the ones whose praises are sung by users, but the flip-side is the severe effects with greater use.

Mood enhancement, euphoria, or dysphoria can become irritability, hostility, and fear; increased energy can become boundless energy and exhaustion; heightened alertness and vigilance can progress to paranoia or increased violence after two or three days of bingeing.

Postponement of sleep may become total insomnia, which leads to the use of depressants, like alcohol, for relief. But unlike other stimulants, cocaine depresses the respiratory system, and taking depressants like alcohol and heroin at the same time can have a syncrgistic effect.

Increased motor activity can become hyperactivity or catatonia.

More self-esteem and better ability to perform under pressure can graduate to grandiose delusions; decreased appetite to total anorexia, emaciation, and susceptibility to infections; and increased libido to lowered sexual appetite.

Cocaine is a mixture of a local anesthetic and a sympathetic nervous system stimulant, Dr Fehr said, and its physical effects are dose-related.

It increases the heart rate and is a vasoconstrictor, leading to a rise in blood pressure and a consequent increase in risk of stroke. High doses can cause cardiac arrythmias, hyperthermia, seizures, and respiratory depression. Vomiting brings a risk of death by aspiration.

"At the extreme end, it can be very toxic, and it can kill," she said.

In the nervous system, cocaine blocks uptake of neurotransmitters such as norepinephrine, serotonin, and dopamine.

Dopamine is excreted from vesicles at the transmitting end of onc nerve across the synaptic cleft, so messages can be carried to the next nerve cell. It is normally recycled back to the vesicles, but cocaine blocks the enzyme responsible for this uptake. Not only is dopamine depleted in the vesicles, but more remains in the synaptic cleft to stimulate the receiving nerve cell. "Its receptors read more messages than are being sent," Dr Fehr explained.

Coca plant

Coca processing

Cocaine

EDITOR
Anne MacLennan

PRODUCTION EDITOR
Terri Etherington

CONTRIBUTING EDITORS
Karin Maltby (Toronto)
Harvey McConnell (Washington)

CONSULTANTS
Dr Oriana Josseau Kalant
(Science)
Robert Solomon
(Law)

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053 Advertising 595-6113 Subscriptions 595-6056

CORRESPONDENTS
John Carroll (New Brunswick)
Maureen Brosnahan (Winnipeg)
John Dornberg (Munich)
Manfred Jager (Winnipeg)
Tom Land (London)
Betty Lou Lee (Hamilton)
Alan Massam (London)
Lachlan MacQuarrie (Hong Kong)
Jean McCann (Cleveland)
Pat McCarthy (New Zealand)
David Milne (Toledo)
Tim Padmore (Vancouver)
Lynn Payer (New York)

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

'You've come the wrong way, baby'

Female smokers defy warnings

If we were looking for convincing evidence that men are smarter than women, and boys smarter than girls, the current changing pattern of cigarette use by the sexes plainly provides it. While males of all ages are quitting smoking, females are increasingly taking it up.

We may wonder in particular, in view of all we now know, think, feel, and say about the medical and social consequences of cigarette smoking, why so many of our young women are still so willingly baring their chests to this deadly practice. And, all the more so when both the Canadian and American Cancer Societies have just announced that this year, 1985, the incidence of death from lung cancer in women for the first time exceeds the incidence of death from breast cancer (and will continue to rise from eighth place where it was in 1960, and second place in 1980) — entirely because of cigarette smoking.

Lung cancer aside, cancer deaths are now falling as new treatments and cures become available. Lung cancer included, the overall cancer death rate is still rising, simply because we are now reaping the abundant harvest of lung disease seeded by the many so-called 'liberated' women who, like Princess Margaret (**The Journal**, April) began to inhale cigarette smoke during and after World War II.

Why are women, especially the young ones, so slow today to get the message, wise up, and quit? No one seems to have the answer, but it is eminently clear that the infamous female-directed cigarette slogan should now read *"You've come* **the wrong** *way, baby!"*

I would like to add that I enjoyed the front page story on drug wars and national security (**The Journal**, April).

George F. Lewis
Associate Professor of Anatomy
McMaster University
Hamilton, Ont

"CURRENT LUNG CANCER EPIDEMIC AMONG WOMEN IS ALMOST TOTALLY ATTRIBUTABLE TO SMOKING!"

— DEAN OF NURSING, QUEENS UNIVERSITY, THE JOURNAL

TJ 'fills the gap' on alcohol info

I am writing to ask for details about the cost of subscribing to **The Journal**. I am involved in the operation of an Alcohol Education Program for offenders for the East Sussex Probation Service and would find it helpful to receive a copy of **The Journal** each month to help update the content of the program.

The Institute for the Study of Drug Dependency is the most informative source in the United Kingdom on drugs other than alcohol and nicotine, hence my writing to you in the hope of filling the gap.

Graham Stevens
Probation Officer
East Sussex Probation Service
Brighton, East Sussex
England

Reader queries WHO concern on smallpox

Despite a general, unreserved appreciation of the contents of **The Journal**, I was disturbed by the lead sentence of your feature item on page 9 of the March issue.

This read, "Alcohol, other drugs and cigarettes may soon rival schistosomiasis, smallpox and typhoid . . . ."

Smallpox! Surely one would expect people working with the World Health Organization to know what it has been up to in recent years, even if it was a different branch.

R.D.P. Eaton
Regional Medical Officer
Atlantic Region
Medical Services Branch
Halifax, Nova Scotia

Correction

A word was inadvertently left out of the article, Children of alcoholics honor Canadian (The Journal, April). A quotation by Margaret Cork should have read: "My study was written, not *only* out of my own deep concern and compassion for these children, but in the hope that since I was near the age of retirement, other caring individuals would follow after me."

The Journal **apologizes for any misunderstanding this may have caused.**

'Informative,' says new subscriber

Please send us copies of your publication **The Journal**. We are very interested in a subscription to your informative newspaper.

Keep up the good work.

Janet A. Richer
Paul-André Richer
Ottawa, Ont

The Journal welcomes Letters to the Editor. Letters bearing the full name and address of the sender may be sent to: The Journal, 33 Russell St, Toronto, Canada M5S 2S1.

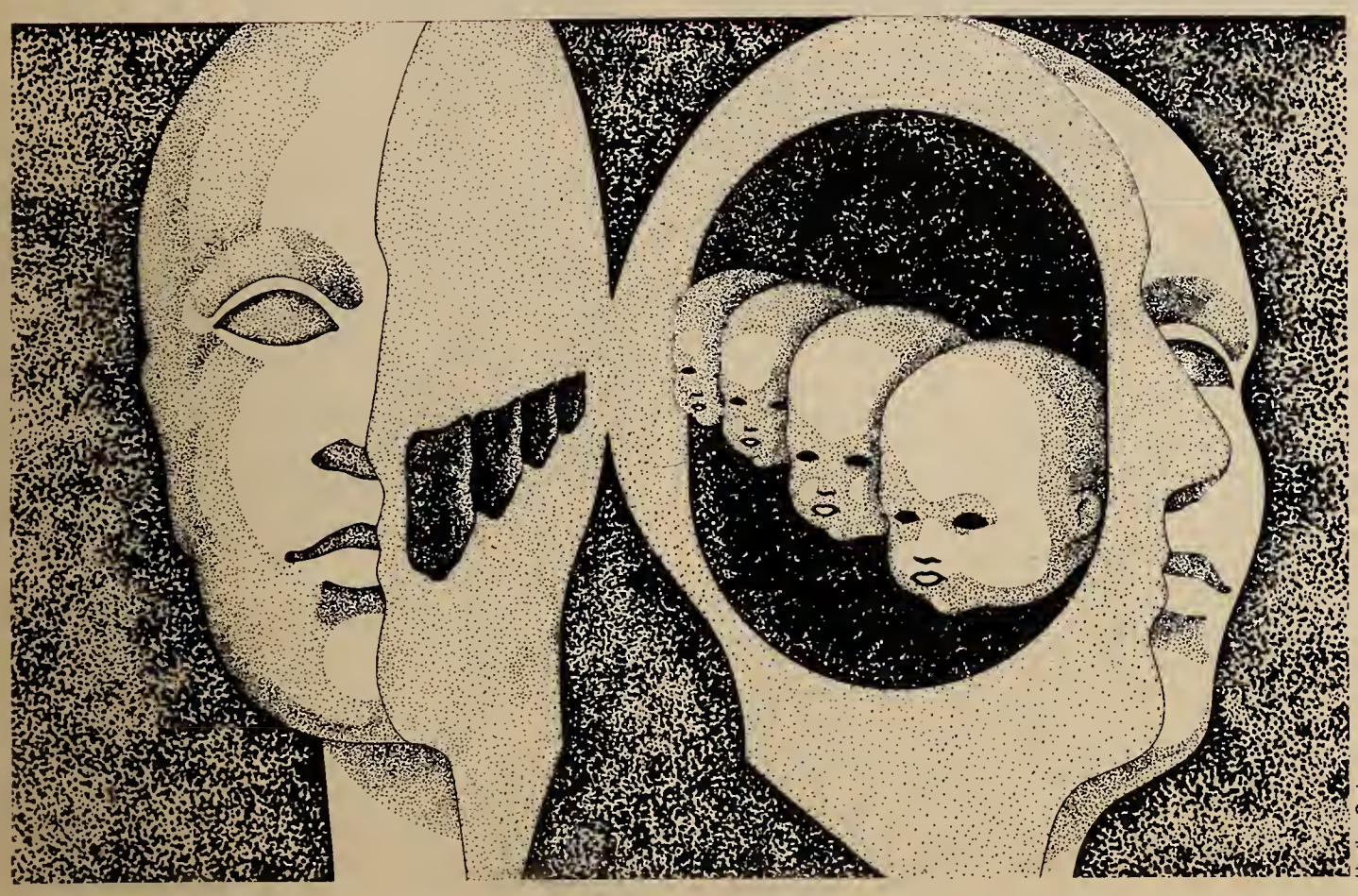
The Children Remembered

— Echoes of parental alcoholism linger on —

Conclusion of a two-part series

The Children Remembered

Part II



Heather Graham

—Echoes of parental alcoholism linger on—

Although experts have studied alcoholic behavior for many years, and have refined treatment programs for chemically dependent people, it has not been until recently that the plight of children who were raised in alcoholic homes has been addressed in any major way.

Adult children of alcoholics are recognizing, for the first time, that the many medical, emotional, mental, and spiritual problems they address again and again, throughout their lives, may be rooted in unresolved childhood issues resulting from their parents' alcohol or other drug dependency.

The problems faced by children who grow up in alcoholic or other drug-dependent homes, do not disappear when they become adults. The phrase used often by practitioners treating this new client population is "adult-children," because the terminology may best describe their outlook on life.

Indeed, those who may seem to be the most responsible and most well-adjusted on the surface often do not even begin to experience myriad childhood-rooted crises until they are well into their 30s.

Janet Woititz, author of *Adult Children of Alcoholics*, has defined the adult-child: "They guess at what normal behavior is; have difficulty following a project through from beginning to end; lie when it would be just as easy to tell the truth; judge themselves without mercy; have difficulty having fun; take themselves very seriously; have difficulty with intimate relationships; overreact to changes about which they have no control; constantly seek approval and affirmation; feel they are different from others; are super-responsible or super-irresponsible; are impulsive; and are loyal, even when that loyalty is undeserved.

In February, in Orlando, Florida, more than 1,000 people gathered to share insights about children of alcoholics. It was the first nation-wide conference of the United States National Association for Children of Alcoholics (NACoA), and the meeting brought together educators, therapists, and other health professionals. But, it also drew adult children of alcoholics who were there to hear validated, in public, their specialized problems and treatment needs.

Last month, The Journal presented Part 1 of *The Children Remembered*, a report which encapsulated and summarized presentations by several leaders in the children of alcoholics movement in the US.

Maltby

KARIN MALTBY, contributing editor of The Journal, attended the NACoA conference, and, on these pages, files the second, and final, part of *The Children Remembered.*

Chronic shock among adult children of alcoholics

Trauma is a part of the human condition. People experience trauma first at birth, and continue to experience it throughout their lives. However, the person who is raised in an alcoholic home deals with trauma in a way that is survival-oriented, rather than resolution-oriented, a condition defined as a chronic shock. Wayne Kritsberg, MA, CADAC, says children of alcoholics rarely have the opportunity to resolve the issues connected to their personal "catastrophes." Mr Kritsberg, director of the Family Integration Center, Austin, Texas, adds that these non-processed emotions affect the way the child relates to himself, and the way he relates to the rest of the world. It is through the resolution of the chronic shock state that emotional integration and wellness occur.

Wayne Kritsberg

When I worked in a hospital emergency room, I noticed that patients in shock exhibited similar physical characteristics.

Their jaws would set; there would be a vacant, distant look in their eyes; and, their skin would become either dry and cold, or hot and and flushed. Because they had difficulty accepting or understanding the physical trauma which happened to them or a loved one, they would experience emotional shutdown and become numb. The trauma was simply denied.

In my own private practice, I noticed that my clients would exhibit those same symptoms of shock.

For instance, a client would be recounting a painful experience as a child from an alcoholic home; his eyes would become distant and his skin flushed; his throat pulse would speed up, and his palms would sweat. In other words, he looked like a person lying on a stretcher in the emergency room.

The client exhibiting these symptoms of shock is re-experiencing unresolved trauma. He doesn't have the ability to process that trauma and is still being affected by it.

When I questioned a client exhibiting these symptoms, he might say: *"I don't feel anything. I feel a little flushed, my heart's beating a little faster, but I don't feel anything else. I can't feel my body. I just feel numb."*

As I attempted to dig out this person's past to ascertain the origin of the shock, it was common for a client not to be able to remember: *"When I think about this period of time, I feel anxiety and stress, but there's a period of time in my life that I don't remember."*

In many instances, adult children of alcoholics have some big chunks of memory that are lost from their childhood. When they think about their early experiences, some big parts of their lives are missing.

I begin to treat these people as if the shock of the event has just happened and work from there.

From the most functional to the most dysfunctional families, a child learns to find a balance within her own family system. When a catastrophe occurs to the child — death, divorce, and so on — it upsets the balance of the child's life to such an extent that the child is overwhelmed by fear.

The catastrophe, in the eyes of the child, is outside of the realm of her everyday experience, and she perceives it to be a threat to her existence.

In a healthy family, the shock lasts for a set time, and the child begins to feel emotional again at what is called the rebound stage.

She seeks to re-establish the balance she had previously. Her family is able to talk about the event, to support her, and to help her understand and integrate the event into her life.

Children think they are the centre of the universe. A child from an alcoholic family will interpret that she is responsible for any trauma that happens to her or her family. She has no feedback or explanations from her parents to think differently. *"I'm at fault that my mother and father are getting a divorce. . . . It's my fault that I got molested because I was walking down the street, and I got into a strange car. . . . Nobody ever told me any different."*

There is no real support for anybody in the family, particularly the child experiencing the trauma.

And, while a healthy family may further support a member undergoing trauma by seeking outside help — counsellors, teachers, peers — the alcoholic family does not. The child of an alcoholic makes the unconscious deci-

'My unhappiness was the unhappiness of a person who could not say no.'

Dazai Osamu

sion to shut down her feelings, because it is her only recourse. She is not able to have the emotional discharge necessary to resolve any traumatic event. The shock remains unresolved.

The trauma is buried, as a survival mechanism, so she can live the best she can with the experience. Forgetting is a survival instinct.

If the incident is not forgotten, the child from an alcoholic family will disassociate from the trauma, repress her emotions, and remember it as if she were an observer, as if it happened to somebody else.

The denial or disassociation from the event is a condition which results in chronic shock for the child of an alcoholic. Not everybody that comes from an alcoholic home, of course, experiences chronic shock, but a high proportion do.

Trauma is a part of life for everyone, but, it is how one deals with those events that separates the person who comes from an alcoholic home, from the person who comes from a healthy environment.

Chronic shock does not go away by itself. I have worked with people in their 50s and 60s who are suffering, still, from events that happened to them as children.

A person in chronic shock experiences her feelings through a narrower range of emotional experiences than other people. She knows anger, grief, and sadness, but describes joy as the absence of pain. Rapture is an unheard-of emotion for her.

And, while she has a narrower range of emotions, those she feels, she feels very intensely. She is likely to be overwhelmed at inappropriate times with grief.

A person in chronic shock has a short attention span. I have had clients forget my questions about their past almost as I posed them. It is a mechanism whereby the person experiencing chronic shock learns to protect herself from overwhelming feelings.

Confused thinking is another characteristic of a person in chronic shock. He is unable to connect thoughts, he may begin speaking very rapidly, and his thoughts will change quickly. This is a clue for the therapist that the client is broaching a painful subject or incident from the past.

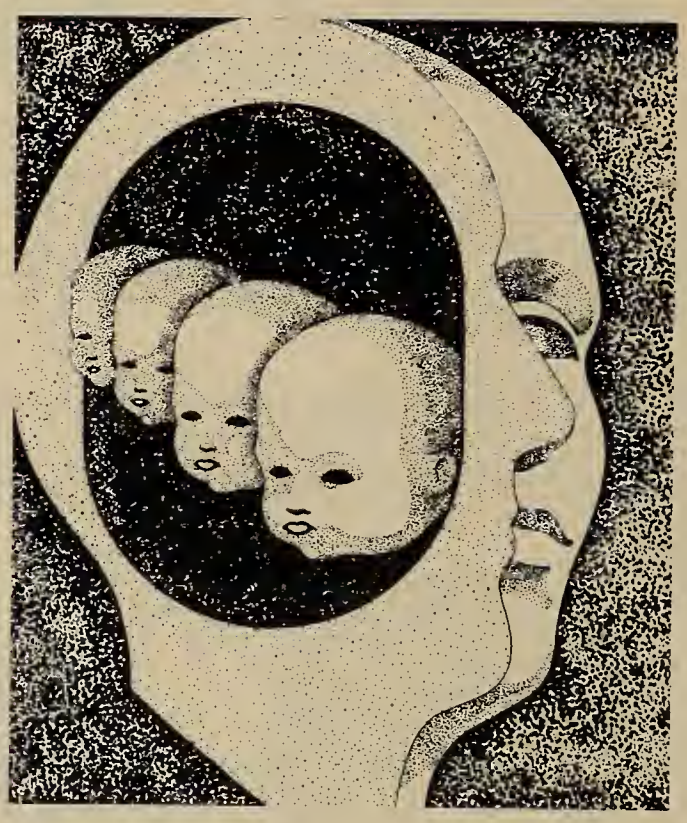
When trauma is not dealt with appropriately, feelings of hopelessness and helplessness stay with that person indefinitely, and affect everyday life.

Some people deny a catastrophic event was of significant importance: *"It didn't happen to me. It's going to go away. It's no big deal."*

I'd like to present the case study of Lisa, a woman now married with children. She was six years old when she was molested for five hours by a neighbor. Both her alcoholic parents and their pastor decided the best way to deal with the molestation was to ignore it. Lisa can remember that something bad happened to her, and that her parents told her to forget it. But she has forgotten what went on for those five hours in her neighbor's house.

Lisa was forced to internalize her perceived guilt. As a wife, she was unable to have a good sex life. She was afraid her own children would be molested, and she feared for her own safety in public.

After six months of group therapy, she began to talk about her experiences. It was a painful process but she was able, finally, to discharge the fear — the chronic shock — that had been inside of her and had affected all areas of her life.



Educating schools, parents, the community

Raising community awareness of chemical abuse problems among children and teenagers requires at least two important processes: education of everyone involved, and coordination among the three primary social networks in which a child lives. Collaborative efforts by schools, parents, and the community to address chemical dependency will effect a positive change, says Timothy J. Allen, MA, executive director of Break Through, an out-patient treatment program for adolescents in Orange County, California.

Timothy J. Allen

In 1969, I was teaching English and coaching sports. I had a group of athletes that was every coach's dream. Five of them signed major league baseball contracts and went from high school into professional sports.

Within one year's time, four of those kids drank their way out of those jobs. They had been in my advanced English class, on the student council, and successful athletically; they told me they had been using chemicals since eighth grade.

As teachers, we thought we could identify drug users by their physical appearance — the length of their hair, and the clothes they wore.

I became a school administrator, and soon realized that the problems I was now dealing with — attendance, behavior, and family problems — all seemed to relate back to the students' — or their parents' — chemical dependency. I began to understand the power of the family because, in discipline matters, I was dealing also with the bizarre behavior of intoxicated mothers or fathers. I was becoming part of their disease, because my own behavior was like that of a codependent. I was angry, resentful, and I would enable. I would make excuses for kids, because I knew what was going on in the family.

I have worked in both a *barrio* high school, where guns and knives were the order of the day, and on a prestigious, upper-class campus. But, the problems at both schools were similar. Chemical dependency knows no boundaries.

As manager of education services for the Comprehensive Care Corporation for three years, I helped establish programs for chemically dependent youth. As I moved around the US, working with communities, schools, and kids, I realized that in-patient treatment is expensive. If a parent doesn't have health insurance, money, or a house to mortgage, his child might not be able to get help.

No-talk rule

We developed, then, an out-patient treatment program called Break Through. It is a program for families affected by chemical dependency, since it is a family disease. All of the things that happen to a person who is chemically dependent also happen to the family. We all (in the family) have the disease and are affected by it. And we must have that attitude if we want to effect change in a system or a community.

The alcoholic family is characterized by the no-talk rule. That same principle operates in both the community and the school system, and in business and industry. We do not talk about the problem, because, if we do, something has to be done. For example, if a school administrator admits there is a drug problem on campus, he must then worry about whether parents will insist he solve it. In turn, the school superintendent will demand the administrator keep the school chemical-free and disciplined.

When kids are affected by chemical use, they also affect their family's behavior. If the teenager is preoccupied with chemicals, so are his parents. All family members are frustrated: a passive father may become violent; a passive mother may become angry. They violate their values system, just as their children who become drug-dependent do.

Youths who abuse drugs also affect their community. Some kids involved with chemicals become involved with criminal activities. About 85% of all crime is committed by people who are under the influence of chemicals, and about 85% of that crime is committed by adolescents.

As a school administrator, my job is to control the activity of the campus, evaluate the teachers, and maintain a learning environment. If students on campus are out of control with drugs, that environment is not maintained.

If teachers have students in class who abuse drugs, they can't do their jobs. One out of 16 high school seniors in the class of 1983 were smoking dope every day; one out of 16 were drinking every day. And, one out of three lived in an alcoholic home. Each of these people affect the classroom. The way they behave affects how the other kids learn.

If we are to treat the student, then, for his chemical dependency, we also must treat the school, the family, and the community.

The biggest change can be made in the school system, because teachers spend more time with students, on average, than their own parents. Teachers are also most likely to see and understand subtle behavior changes, attendance lapses, mood swings, and other symptoms of chemical dependency.

In every school campus, we know that there are students who don't use drugs at all, those who experiment, those who use regularly, or those who are already chemically dependent.

Existing drug education, awareness, and prevention programs are missing some of these groups.

For example, a prevention program I analyzed was effective in grades kindergarten through six. They have an effect on kids who don't use and on those who experiment, because they teach the development of self-esteem, teach kids to say "no," and so on. However, prevention programs don't have much of an effect from ages seven through 12, because they leave out students who are already drug users. The largest growing group of kids experimenting with drugs today are in the age group of nine to 14 years.

Grasping to hang on

In drug-awareness programs, typically, a speaker is brought into the school to talk to students about drugs. Some schools liken this one-day seminar to a drug education program. However, when a recovering alcoholic or drug-dependent person tells their horror stories to students, the kids think: *"See, he made it."* Teens are grasping to hang onto any last grip that they have to maintain a relationship with chemicals. If they believe a speaker abused drugs for many years and "got clean," they believe they can do the same thing.

Awareness programs do have an effect on a certain school population. Kids who don't use drugs and those who experiment are persuaded to avoid chemicals. However, when I talk to 2,500 students at one time, 500 of them will not want to hear what I have to say. Kids who are already using drugs shut me out.

The educational approach takes place, usually, in a secondary school health class. For about six weeks, drugs are discussed: what is the drug; what it does; its pharmacological effects; and how much it costs.

Addicts are sometimes brought in to verify this information. But, this approach actually creates more interest in drugs by sparking students' curiosity. In the 1970s, we told students that marijuana would lead to heroin, and that they would die. But, through their own experimentation, we, as teachers, lost our credibility. *"The stuff was great. Nobody freaked out. Nobody died."*

Another type of program which affects every student is the disciplinary approach: *"If you find the kid using drugs, get rid of him."* A student with a chemical problem is expelled and might be sent to an alternative school.

Kids who don't use drugs, or who experiment, are affected by this approach because they are too scared to face the discipline. The administrator has done his intervention but, in most cases, the response of the parent to the student who's drunk in class is: *"Thank God he wasn't smoking dope."*

The problem is that the student has progressed through the disease before we identify it. We know that chemical dependency is a primary, progressive, chronic, fatal disease. It is the leading cause of death for teenagers. Behind drug overdoses is suicide, and most suicide is committed by kids while under the influence of chemicals. We're losing 12,000 to 15,000 youths a year in the US as a result of alcohol and other drug-related incidents.

The goal of any kind of program for kids is to get them at the non-user level.

Alcohol/drugs unacceptable

Prevention and education/awareness programs should go across-the-board. The mandate of a disciplinary program should state: "Alcohol and other drug-related problems are totally unacceptable on this campus. But, if you have a problem, we would be more than happy to help."

Teachers need to be able to identify problems early on, and know that if they did identify kids at risk, there is a proper way to intervene.

The no-talk rule needs to be broken. The community-at-large must understand that chemical dependency is a problem for all. But, typically, we play the blame game. The parents blame the school; the school blames the parents; the community blames the parents and the school. The school and the community also blame the lack of enforcement and reinforcement of laws by police. Everybody is blaming everybody else and the kids are not getting any help.

The community must decide what it can do to help its kids — and its teachers — do a better jobs in the classroom.

The level of awareness with school administrators, board superintendents, and teachers must be raised as well. It is not an attempt to create mini-narcotic agents and mini-psychologists. But, they can set some standards — and the community must help them — as to acceptable and unacceptable behavior, and to hold children responsible. If students don't live up to those expectations, there must be a process by which they can get the help they need to change their behaviors.

Teachers need to be taught the disease concept of chemical dependency, and the concept of family disease. While many teachers think they do not have a problem in their own classrooms, once they begin talking to their students about those concepts, the no-talk rule has been broken.

Students will not be afraid to step forward and seek help, either for themselves or their friends, if these awareness and education programs are presented in the right way. The disciplinary aspect should not be a "go-after-them, go-get-them" approach, but a "go-after-them, go-get-them, and help them" approach.

We need also to break the silence for children of alcoholics early on. There are now support groups for these kids on some campuses. Teachers, who themselves are adult-children of alcoholics, are opening up to their students and sharing with them their feelings, and the effect familial alcoholism had on them.

Community people are very important to the success of any kind of program which goes on in the school. They must be philosophically in line with what the school system is doing. They must all agree on what the acceptable and unacceptable behaviors are, and act accordingly. The school, for example, cannot suspend a student for being drunk at a school dance, and then have parents feel their child is being picked on.

One community I worked with advertised in the newspaper: *"We, the parents, would like to see chemical-free parties, and we do not support or condone any parent who actively supports a party at their home in which kids are served chemicals. If we find out who that person is, we will ask that person to stop, or we will press charges."*

Community people must approach the school and show their support and willingness to help. However, school people are protective of their environments and don't want others, particularly parents, telling them how to do their jobs. People in the community, therefore, must approach the school with some ideas that will make the faculty's job easier.

Monetary incentives

Parents' groups who can raise money to help fund drug programs for schools are important, because funding is being cut all of the time. For example, good educational materials are needed, but are not affordable.

Once a program is implemented in a school, somebody must be in charge of running it. Administrators and teachers are busy, and may need monetary incentives to add this responsibility on to their workloads.

Change, however, takes time. Change needs to be based on sound theory. People have to be motivated, and need to believe that what they are doing is going to make a difference.

Teachers and administrators have sat by and watched all kinds of programs come and go: *"If I wait long enough, this will go too."*

The essence of good-quality drug programs for kids lies in good-quality people. A support network must be in place so that if one person leaves, the whole program doesn't leave with him or her. Everybody has to have ownership. Everybody on the drug program committee has to have power, and everybody has to believe that they can make a difference.

Treatment of depression and unfinished grief in adult children from alcoholic families

Children of alcoholics show up disproportionately in the psychiatric literature and in clinical settings, with a wide range of problems: depression, isolation, and unresolved grief. Lorie Dwinell, MSW, ACSW, says she hates the word "sick" when applied to human behavior, because it implies some people do better than others in therapy and "griefwork." Ms Dwinell, who is a therapist in private practice in Seattle, Washington, quotes from Alcoholics Anonymous: *"We claim spiritual progress, not perfection."* All children of alcoholics, she adds, are progressing toward a more integrated and comfortable state of being. "There is no point at which one begins grieving and finishes. In fact, it's a process that gets worked through again and again."

Lorie Dwinell

Grief is the pain that heals itself. It is the most normal of human emotions, requiring the presence of at least one other person, since it is a socially-facilitated process.

Griefwork then, breaks all the rules of the alcoholic family system. Those unspoken rules are: *"Don't trust, don't talk, don't feel, and family business is family business."*

The natural healing process of grieving breaks through isolation, which is endemic to individuals in alcoholic families. It involves finding a commonality with others who have had similar experiences. For an adult child of an alcoholic, the sense of being different is something he has carried all his life. To be different is to have a secret that makes him feel guilty and ashamed. Because he cannot share his feelings, his resolution of grief cannot be worked through.

Grief is also a time-dependent, life-long process in which an adult-child learns to deal with issues which permeate the core of her being.

All victims of trauma, such as survivors of familial alcoholism, work to achieve emotional and cognitive reconstruction of that trauma, to work it through, to make sense of it, so it can be lived with.

The effect of severe trauma on a fully-developed personality is some degree of personality disintegration. For an adult-child, too much emotional energy is put into survival rather than into a process of reaching out and exploring the environment with spontaneity and creativity.

Psychic numbing

Some people who experience severe trauma succumb totally to that destructive influence. Others function well, provided they are in a safe environment, but are fragile personalities when at risk. However, another group are able to re-experience the pain of the original trauma, and to work it through.

Adult-children develop various mechanisms for survival. One is called "the mask." Children of alcoholics have been ignored as a treatment group for a long time because they look so good. They adopt an outward appearance of competence — a mask — while disguising how frightened they're feeling.

Other adult-children develop observer-selves. This is the ability to become an observer of one's own actions — a feeling of splitting off from the self.

Survivors of trauma also experience psychic numbing. Adult-children have experienced so much surplus of feelings, yet a surplus of denial becomes requisite in order to function.

At one time, therapists said children of alcoholics had adjustment disorders — an abnormal reaction to a normal situation. But, in fact, observer-selves, psychic numbing, and so on, are the only ways in which adult-children can exist on a daily basis in the face of chronic trauma.

In an alcoholic family, the alcoholic's primary intimate relationship is with the substance. The codependent's primary intimate relationship is with the illness, and that leaves very little room for parenting. One observation Margaret Cork made in her book *The Forgotten Children* (**The Journal**, April), is that one of the major traumas in an alcoholic family is that children experience themselves as either unparented, or inconsistently parented.

Few families 'normal'

Virginia Satir once said that only 4% of the families she had ever worked with could be called "normal" and "healthy." However, there are still parameters by which one can define a healthy, functioning family.

In such a family, the parents have an intimate relationship with each other, and are able to function as a coalition. However, in alcoholic family systems, the marital coalition breaks down, and inappropriate alliances begin to develop. Instead of the marital pair having a union with each other, they tend to go outside the system.

In a healthy family, there is also a parental coalition and there is some degree of bilateral problem-solving. In alcoholic families, though, we see the children becoming the parents. Childhood is pre-empted prematurely, and the child becomes a parent to herself, to her siblings, and to her own parents.

Functioning families maintain generational boundaries which exist for a reason. Adults must be adults. Children must be children. When we see a violation of cross-generational boundaries, as in alcoholic families, there is also, sometimes, incest.

It is difficult in an alcoholic family for a man to be an appropriate role model for maleness, for being a father, for being a husband, if he's actively alcoholic. Likewise, it is difficult for a woman to be an appropriate role model for femaleness, for being a wife, for being a mother, if she is alcoholic, or if she is a codependent.

When I work with adult-children, I ask them to examine people whom they consider to be role models, and to take notes on their behaviors. Most of the time, the people they choose are very much unlike their own parents.

When an adult-child develops substance abuse herself, it is ironic, because her whole life history has been predicated on proving she's not like her mother or father. To acknowledge her own substance abuse, and begin her own recovery, means she has failed in being unlike her parents. This becomes a real impediment to her recovery.

The textbook family, then, that "nobody" comes from, has a wonderful marital coalition with good communication, a tremendous breadth of tolerance for lots of affect, and parents who like being parents, are skilled at it, and who work in a collaborative fashion *vis à vis* their children. They are people who know appropriate boundaries and the appropriate province of the parents vs the appropriate province of the child. He or she knows how to say things like "because I said so" without being too authoritarian. Finally, they feel good about their maleness and their femaleness.

A lifetime process

The lack of those characteristics in an alcoholic family results in a process of developmental lag. This is what the grieving process is about. People who became adults too soon must now go through child developmental stages in order to reintegrate and claim the child within them.

What is there to be grieved? First, what never was. For instance, if a person loses a parent by death, desertion, illness, or alcoholism, certain experiences are missed.

Grief is a lifetime process in that there will always be stimuli in the environment which will kick off different stages of grieving. An adult-child will grieve parental alcoholism in many ways. If she has an alcoholic parent who is no longer alive, for example, she may grieve at the time of the birth of her first child because her parent cannot be present for her passing that developmental stage.

Or, when an adult-child reaches the age at which his alcoholic parent died, he will grieve and feel extraordinarily anxious, because there's a sense that he's scripted to have the same fate as his parent — that he will die at the same age, or that it is inevitable that he will develop alcoholism.

Denial is the key variable which leads to unresolved grief. An adult-child lives life as if it was a rehearsal for traumatic events — always ready for the next trauma — and pre-empting any spark of spontaneity and creativity. She develops a hypersensitivity to issues of loss and abandonment in an environment which predisposes her to problems of depression.

Accepting the reality

Any definition of depression profiles many of the people who have grown up in alcoholic families. Depression is one of the ways of describing unresolved sorrow or grief about one's life. What happens in dysfunctional families is that children have lack of choice and flexibility, and life is lived as a defensive maneuver.

There is nothing pathological about grief. What is pathological is when it cannot be resolved because feelings have been numbed. Normal grief reactions involve feelings of loss, shock, denial, depression, guilt, anger, and, finally, reconstruction. The next stage of grief resolution is depression. It is normal, in the face of loss, to experience depression. If an adult-child defines himself as sick because he felt depressed in recovery, that's a very normal reaction to some of what is surfacing in therapy.

However, one does not begin to deal with grief until there is social support. Adult-children allow themselves only that degree of emotional catharsis which is in direct correlation with the amount of support they have available. When they do not have that support, there is little possibility for griefwork with a therapist.

The first stage of grief resolution is to accept the reality of the loss.

'Something was dead in each of us, and what was dead was hope.'

Oscar Wilde

'Children begin by loving their parents; as they grow older they judge them; sometimes they forgive them.'

Oscar Wilde

The second stage is to experience the pain of grief. The only way to the other side is through the middle. There are no shortcuts in grief resolution, and there is no way to resolve grief without allowing oneself the pain and the anguish. But, there are multitudinous ways to stop the process, get stuck, and not be able to move forward in time.

The third stage of grief resolution is the acknowledgement that what is lost is lost and isn't going to be regained. It is an adjustment to the reality of the environment.

The last stage is to begin the process of withdrawing emotional investment from that which was not, and to become willing to move forward in time. Some people stay stuck in adolescence forever, angry that it wasn't the way they wanted it to be. For healing to occur, there must be a process of making restitution for the loss, rather than spending a lifetime in yearning.

Some adult-children, who have had very difficult environments, spend the rest of their lives in a state of expected entitlement. People close to them are psychologically blackmailed. They must recognize that while they experienced a loss, they are entitled to nothing special now, nothing more than any other person.

For therapists who deal with unresolved grief and depression issues with adult-children, it is important to do family-of-origin work. Clients must be able to talk about how their lives were and how they were not. Adult-children must begin to see their parents as victims themselves. Parental alcoholism may have been an anesthetic mothers and fathers consumed for dealing with pain they could not resolve in their own family systems. Thus, the griefwork of adult-children entails the willingess to forgive: *"I have to be done with this, I have to move on, and I can't be angry forever."*

Child sexual abuse and alcoholism: the intimate connection

There is a statistically high correlation between child abuse and alcoholism, says Linda Sanford, LICSW, the author of several books on sexual victimization. When she began her work as the coordinator of the Sex Abuse Unit at Coastal Community Counseling Center, Braintree, Massachusetts, she suggested the program be called the "Abusive Power Unit." Ms Sanford, who also has a private practice in feminist therapy with adolescents and women, describes incest victims and their families as "upsidedown," with the role of the children being to take care of the parents.

Linda Sanford

An infant girl born in the United States today has a one-in-four chance of being sexually abused by the time she's 18 years old. An infant boy has a one-in-seven chance of being sexually victimized.

Those statistics cover a range of sex crimes ranging from exhibitionism, rape, child prostitution and pornography, to incest. The average age of a child sexual abuse victim in the US is eight years; the average incest offence goes on in a family for three to five years.

Eighty-five percent of incest offenders are men, and 15% are women. A genealogical map of families in which incest occurred will reveal, in 90% of cases, past histories of incidences of either alcoholism, sexual abuse, physical abuse, neglect, or a combination of those.

During the past 11 years, I've worked with more than 600 women and children who have been sexually victimized. A girl is far more likely to be molested by someone in her family, while a boy is much more likely to be molested by a coach, teacher, neighbor, or friend of the family.

When a child comes to me for treatment, I tell them: *"You're not here because you're sick, crazy, weird, or because you did anything bad or wrong."* She wants me to help her answer her important questions: *"Why did he do it? Am I okay? What's going to happen to him? Why didn't I tell anyone?"*

Children who have been sexually abused, particularly for a long period of time, have an internalized, evil sense of self. They are angry at themselves and not at the offenders. But, a woman must understand that what happened to her as a child had nothing to do with responsible, consenting sex between two people.

The intention of the offender was not sexual gratification, but abuse of power. It's that imbalance of power that is attractive and arousing to him. As long as there is somebody that is more helpless, more powerless, more out-of-control than he is, then he can feel better.

Most offenders and their victims are referred to as incestuous families by many therapists. But, families don't commit incest — offenders do. There is the mistaken belief that a family system in which there is conspiracy and

collusion creates an atmosphere conducive to child sexual abuse. However, the vast majority of offenders have a predisposition to abuse children sexually before they had families.

The responsibility for the offence must lie with the offender. It was his choice, and it was his decision. The family cannot share the responsibility for his actions.

When a therapist examines the marriage of the offender and his wife, she will likely see two needy people who feel insecure, inadequate, have low self-esteem, and who experience the world as a cold, cruel, and unpredictable place. They married each other to buffer themselves against the outside world.

They tend to raise large families. I have rarely worked with an incest victim who is an only child. The average size of a family with an incest offender is between four and six children. In our clinic, we have many families that have between nine and 12 children.

These needy couples have many children because their offspring are yet another buffer between them and the outside world. And, if they can't have birth children, they will adopt, take in foster children, or pick up street kids. Many times we have found that convicted offenders still had applications in process to be foster parents.

Dysfunctions appear early on in the marital relationship. Sometimes there's sexual dysfunction between the husband and wife. However, about half the time, offenders are sexually active with their wives while they're molesting their children.

Power imbalance

There is a power imbalance within the marital diad of an incest offender and his wife. In about 70% of couples we work with, the man is authoritarian, totalitarian, and rules the family with an iron hand. The wife is timid, passive, and submissive.

The other 30%, however, are marital diads in which the man is debilitated either through alcoholism or some other disability. He's seen by his family as pathetic while his wife carries on the role of the aggressive breadwinner.

In both diads, these couples have looked to each other first to meet all their needs. But, their needs were not met, and the relationship buckled under that kind of pressure. They turn then to their children with a new intensity, feeling that their offspring can make them feel worthy and whole, and give them the gratification that they couldn't get from each other.

In a family where there is any kind of abuse, the children begin to take on the responsibility of looking after the physical and emotional well-being of their parents. Generally, the oldest daughter becomes a little mother to the younger children and also to her mother and father. It's not a big step from being a little mother to being a little wife.

All incest victims have in common a real sense that their family is going to disintegrate at any moment. An offender senses his victim's unease with the family's security. So, when he introduces the incest, he may say: *"As long as you do this, I won't leave. You're the only one who can make me happy, and meet my needs. Your mom is a bad mother and a bad wife. This is how a daddy who loves his little daughter acts."*

The child thinks of the incest, then, as something she can finally do to keep the family intact: *"I'm going to keep this family together, and protect my younger brothers and sisters from this abuse."* The child has been trapped by the offender.

I don't believe that mothers collude in sexual abuse. My experience is that mothers rarely know what's going on at the time, but, like the rest of us, they have terrific hindsight.

When the incest is carried on during a long period, one of the generalizations made about the mothers is that they're poor nurturers and protectors. They're not perceived by their children as effective people whom children can turn to with problems. But, that's not the same as being an offender, and it's not the same as collusion. The responsibility needs to be with the offender.

Mothers as enablers

Mothers, however, can be enablers by protecting their husbands from the consequences of their actions. Once the secret is out, they'll be protective of their husbands.

Both the offender and his wife are, in high probability, the adult children of alcoholic parents, or victims of sexual or physical abuse or neglect. Eighty percent of the offenders in my program are now substance abusers themselves.

Many incest offenders have driving-while-impaired charges. It's not at all unusual that they can't come to group therapy because they lost their licences.

There is a tremendous amount of violence in families with incest offenders. Everyone "walks on eggshells" in fear of the offender's temper. It's a volatile situation often related to the offender's alcoholism. And, therefore, it's not the kind of atmosphere which is conducive to confrontation, where a mother can say: *"What are you doing to my children?"*

If the mother has been a victim of sexual abuse herself, she'll often have a sense of resignation about the incest. *"This is something that big men do to little girls."* For these women, group therapy is the treatment of choice.

We also see a tremendous incidence of offenders who have criminal involvement. An offender's attitude to a breaking-and-entering offence is the same as to incest: *"Give me your property, or give me your body."*

An offender may admit he has a drinking problem: *"You finally convinced me. I'll go to detoxification. I'll undergo rehabilitation. I'll attend Alcoholics Anonymous meetings. And then, I'll stop offending."* While it's true that 80% of the men do have a *bona fide* substance abuse problem, one kind of treatment isn't going to take care of the other problem. They need treatment for both.

Offenders don't offend because they're drunk. They drink to offend. They drink to break down inhibitions and to alleviate whatever guilt is there.

Mind-body split

When victims come to therapy, they can only progress once they can begin to divorce their own sense of worth from the experience of the abuse.

As they were molested, they went through a mind-body split. This becomes an important issue. Their minds can't compute the overwhelming experiences of the incest. Victims tell me: *"I pretended it was happening to somebody else, and that I was a spectator."*

For a victim, this mind-body split becomes a way of dealing with any kind of threatening situation on into adult life. Incest victims are targets for multiple victimization. They get raped, they get physically abused; all kinds of things happen.

The process of healing from child sexual abuse is like the old therapy cliché: *"Sometimes when you think you're going crazy, you're going sane."* These victims have survived through repression and depression.

We have found a tremendous amount of substance abuse among incest survivors. I use the word "substance" loosely; it's liquor and drugs, but it's also sex, television, travel, food, and so on.

As with alcoholics, sexual offenders can be rehabilitated but they must always be vigilant about their relationships with children.

As therapists, we try to teach offenders a lot of replacement behaviors. These men are stuck at a very early developmental stage. They're very young emotionally. We work in male/female teams, and we use a modality of corrective reparenting. It is an attempt to go back and pick up the developmental tasks offenders' own parents missed.

The Journal *would like to hear readers' comments on the issue of familial alcoholism and codependency. Write to: Letters to the Editor,* **The Journal**, *Addiction Research Foundation, 33 Russell St, Toronto, Ontario, Canada M5S 2S1. A limited number of bibliographies and the mailing address for the United States National Association for Children of Alcoholics are also available.*

FEATURE

Revenue/health debate puts clamps on global efforts on alcoholism

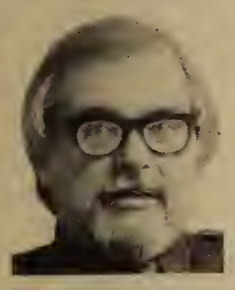
Maplines

GENEVA — Illicit drug use is skyrocketing in many developing countries, with its attendant public health, security, and crime problems. Less publicized, but potentially even more crippling if not controlled, is the rise in alcohol consumption.

It is a double-edged sword for many countries: in the short term, increased alcohol consumption means more revenue for the state. The public health problems could be 10 or 20 years away, a time when most prime ministers and finance ministers will have long gone from office.

There has been a steady, global increase in alcohol production and consumption during the past 20 years. Consumption has started to drop in some countries with a history of alcohol use, but in the developing world there is a dramatic increase.

"A striking feature is the number of developing countries which are now vocally indicating that they have increasing problems, and they want to do something about them," declares Marcus Grant, senior scientist and manager of alcohol programs at the World Health Organization's (WHO) headquarters here. "Ten years ago that wouldn't have have been the case."



McConnell

In the second of his reports from Geneva, contributing editor HARVEY McCONNELL talks to Mr Grant about the role of the WHO.

In the past decade or so, foreign commercial interests have become more involved in beer and spirit sales in the developing countries.

In Africa, for example, beer is generally not imported from abroad, but technology is, from both Europe and North America. Much of the increased beer production is made under licence or franchise.

From the point of view of the developing nation, as Mr Grant explains, increased production by a local brewery can be an important source of revenue and of employment, and it will probably use local agricultural supplies, which means raw materials do not have to be imported.

Apparent economic benefits can be quite substantial, while the health costs are a few years down the line.

With spirits, there is less encouragement of domestic production. Growth has been striking in some areas: a 900% increase in production in Korea during the past 20 years.

Two points should be considered, Mr Grant says. The first, is that many of the countries have little past experience of drinking, and though there has been a dramatic increase in consumption, or production, the amount is still less than would be considered worrying in a European country.

On the other hand, if the trends continue — and they show every sign of doing so — then 10 years down the line production levels in some countries will be comparable with those in European countries. The worry, at the moment, is the trend, not the amount.

Village brews

The second point to consider, according to Mr Grant, is that many countries have had non-commercial alcohol available in village brews of one kind or another. "What we don't know, and it is something we have to find out, is whether commercial alcohol is being added to the traditional alcohol, or whether it is replacing the traditional alcohol."

In some countries, more than 50% of the alcohol produced would be of the non-commercial variety. Even in developed countries, although statistics are hard to come by, there is a similarity: it is estimated that up to 30% of the alcohol consumed in Norway is from non-commercial sources.

"If it is 30% in Norway, what is it in Kenya, or Nigeria, or Zimbabwe?" he asks. High, by guess, but no one really knows.

Mr Grant notes that in turning to the WHO for advice, officials in many countries are aware they can do something about their perceived problems, but they are not sure what is the best thing to do.

The agency deals directly with the minister of health. And, in many countries the minister of health is not in the most powerful political position. Many ministers are not even members of the cabinet.

Thus, the finance minister can see the immediate economic benefits of promoting alcohol, and as he is a member of the cabinet, his voice may carry more weight than that of the minister of health, who is aware of the potential health and social problems, and who knows what he wants to do, but may not be able to do so easily.

Unacceptable promotion

Alcohol is advertised and promoted in developing countries in ways which would be unacceptable in Western Europe and North America.

While it varies among beverages and countries, the message "is a very firm association between the beverage and social and sexual success," Mr Grant says. It is an area in which more data are needed before any detailed decisions are made about what should be changed.

Mr Grant thinks that politically-successful movements, such as Mothers Against Drunk Driving (MADD) in the United States, are probably not comparable with movements which may arise in the developing countries.

On the other hand, "the women's movements in many developing countries are beginning to gather impetus," he points out. While they may not be as well organized as those in North America, the potential for popular movements generally to influence legislation and national policy may be quite considerable.

Because they have such a youthful population, scores of developing countries are worried about drinking and driving. There is a paucity of good statistical data on the percentage of accident in which alcohol is involved, but, whatever the proportion, many will consider it too high.

Part of the picture

The rise in commercial production and involvement of the multi-national companies raise a number of questions. From the public health point of view, it may be that the quality control on commercial beverages is so much better than that of traditional beverages that cases of alcohol poisoning won't occur.

Conversely, it could be argued that some of the nutritional value of some of the traditional beverages is absent from commercially produced beverages.

Mr Grant says "it is simplistic to say 'tut, tut, naughty multi-nationals should not be marketing alcohol at all in the developing world.' " Many countries are moving toward greater industrialization and consumer economies, and alcohol is part of the picture. And, what is happening in the alcohol market is no different than what is happening in a host of other markets, such as sewing machines, automobiles, or telephones.

Public health interest

But, because alcohol is a special commodity, and because it carries public health risks, it has to be subject to special controls. That is why the WHO is interested; because there is a public health interest. Mr Grant says the agency has no wish or right to talk to multi-nationals about their behavior in general, or what they are doing.

It is not the role of the WHO to say that alcohol should be eliminated around the globe. It is neither practicable nor compatible with the agency's aim to achieve health for all by the year 2000.

"That doesn't mean having an alcohol-free globe by the year 2000," Mr Grant says. "But it certainly does mean having better prevention and better strategies."

One of the most important things the WHO has accomplished during the past 10 years, he believes, has not been particular projects in particular countries, but rather a change of definitions: from looking at alcoholism as a narrowly-defined dependent state to looking at it as a much broader range of alcohol-related problems.

This shift of emphasis has had a fundamental importance in terms of the way alcohol policy, treatment systems, and prevention strategies have developed in much of the world.

Mr Grant sees the WHO policy moving on three fronts.

The first is advocacy: increasing the awareness of the government, general public, and the scientific community of the health consequences — a slow process, saying the same things in different guises in order to keep them on the agenda.

A lasting change

One way of measuring increased awareness is by monitoring the number of articles and programs about alcohol. The bottom-line is this gradual, increasing awareness "because without it, nothing else is likely to happen that will make a lasting change."

The aim is to make people aware that alcohol is a health issue; it is not to say that people should drink less or not drink at all.

A second front is national policy. Mr Grant points out that if a country wants to do something about problems it believes it has with alcohol, then the effort has to be carried out on a broad front, involving not just the ministry of health, but the ministries of transport, finance, justice, and tourism, as well.

A written policy is not necessary, but to achieve an integrated approach it is necessary to have an understanding about what the country thinks about alcohol.

So far as possible, the WHO would like to strengthen the role of the ministers of health "so that they are better able to influence colleagues when talking about alcohol policy, and it is not just economic gains that predominate," he adds. "In WHO terms we like to think we can do that within an overall health development context so that alcoholism is a very special issue."

It is striking how alcohol problems can be interwoven with other health issues. At times, alcohol may amplify problems which already exist.

Mr Grant believes that in developing countries there are opportunities, at times, for quick action, while the developed countries, in many cases, are slower to change, although the success of MADD in the US proves there is always an exception, he says.

Primary care

The third front is the WHO's commitment to primary health care, or health care at the point of first contact. Much of the expertise in alcohol treatment has developed at the specialized level, and there is a need to transfer this appropriate technology to the primary care field.

Mr Grant: "If someone goes along to see the family doctor, or the community nurse, or the village health worker, whomever they see should know about alcohol problems. And, if there is the beginning of an alcohol problem, they are going to be able to notice it and help do something about this."

By this action, many people who are just starting to drink a bit too much, or who are on the verge, perhaps, of getting into real difficulty, could be turned slightly so that they could continue to drink but not have alcohol problems.

One worry is that alcohol problems may rise quickly in those countries which are least equipped to do something about them. On the other hand, Mr Grant believes to talk about global strategy is inappropriate: the ways in which responses are made to problems have to be compatible with the cultures.

NEWS

Abstinence is cornerstone of treatment in France/US

Consequences of alcohol same in any setting

BOSTON — Per capita consumption of ethanol is more than twice as high in France as it is in the United States, but apparently alcoholism is alcoholism regardless of cultural setting, says Cambridge, Massachusetts researcher William Clark, MD.

Dr Clark, who recently spent a year in France conducting a four-year follow-up study (1980-84) of 91 alcoholics, is assistant professor of medicine at Harvard Medical School and associate director of medicine at The Cambridge Hospital. He told the 8th Annual Alcoholism Symposium here that "the disease in France appeared to be very similar to what I had experienced in Cambridge. The defences were the same and the consequences were similar."

In Cambridge, he had done a long-term follow-up of 100 alcoholics eight years (1971-79) after detoxification. The death rate was 30%, the remission rate was 30%, and the relapse rate was about 25%. The population was highly disadvantaged.

Dr Clark: "Alcoholics Anonymous (AA) had been used by 29 of the recovering Cambridge alcoholics in remission; and 15 of the 31 with improved psychosocial scores were active in AA."

During his year in France examining alcoholism from a cross-cultural perspective, Dr Clark was research associate at Centre Louis Sevestre, Tours. The centre is a 120-bed former tuberculosis hospital with an average stay of three months. It is the only publicly-funded alcoholism rehabilitation unit in France, and its treatment philosophy is abstinence-oriented.

The 91 patients that he followed up in the Tours area had been studied in 1980 by Dr Thomas Babor of the University of Connecticut School of Medicine.

Noting that only preliminary data analysis is available, Dr Clark said: "Our analysis shows that 40% of the men and 30% of the women were doing well at four years, and the death rate was less than 5%.

"Age, educational level, length of stay at index admission, and biochemical parameters did not predict outcome. For the men, a low LeGo (a physical exam 'specific' for alcohol dependence) and low scores on liver function tests correlated with good outcome."

Self-ratings of certain aspects of "quality of life" were also tied to favorable outcome, he reported. "For the smaller number of women studied, the LeGo score and one aspect of the quality of life self-rating were correlated with abstinence."

At the heart of the Tours centre's abstinence-oriented treatment program is work rehabilitation. Those without useful skills are put to work growing vegetables and helping in the kitchen. Work group leaders are experienced counsellors who encourage people to talk about their alcoholism while they are working.

Treatment includes group sessions, family involvement, self-help, and follow-up care. Dr Clark said: "There is also an emphasis on sports and getting in physical shape."

Clark: similarities

Although AA is large in Paris, it barely exists in Tours. Many rural people have no cars to transport them to meetings located in more heavily populated areas.

Dr Clark said that in France, which has the highest cirrhosis death rate in the world, "beer consumption is increasing while wine consumption is going down." Yet wine remains the dominant industry and is more popular than spirits or beer. "Alcohol is ever-present in France."

Looking at drinking patterns during the 30 days prior to admission, Dr Clark found consumption to be much higher in France than in the US.

During recovery, "men and women made about the same progress," he said. "Only four of the 91 patients were dead, with three deaths due to drinking and one due to suicide." The suicidal patient had been abstinent.

Those who started with a higher dependence on entry fared better in recovery, and those with higher severity of liver function at intake were doing better at follow-up.

Dr Clark: "It is clear that alcohol treatment in France is effective." One difference between approaches in France and the US is less emphasis on self-help, he noted.

Dr Clark, who is concerned with teaching physicians more about addiction and what to do with patients coming off alcohol, said that clinical conclusions based on study of the two treated populations of alcoholics in Cambridge and in Tours were as follows:

- The disease of alcoholism has a similar character in both populations.
- Alcoholic people can get well in both countries.
- Abstinence is the cornerstone of treatment in both countries.
- There are substantial differences in the treatment models.
- A poor prognosis at intake does not mean patients cannot have a good outcome.
- Certain populations of drinkers have a very high mortality.
- The drinking outcomes correlate strongly with the psychosocial outcomes (abstinent people have higher psychosocial scores).

By Tom O'Connell

Clinical signs can eliminate routine endocarditis test

CARMEL, Cal — A procedure commonly used by physicians to check for a serious, infectious heart disease in intravenous (IV) drug users admitted to hospital with fever, could be safely avoided in two-thirds of cases, a California study has concluded.

Robert Dubois, MD, reported on the study done at the Harbor-University of California, Los Angeles Medical Center, Torrance, at a session during the annual meeting here of the western section of the American Federation for Clinical Research.

He said the investigation was undertaken to see how cost-effective it was to perform echocardiograms on all IV drug abusers with suspected infectious endocarditis.

When such a patient presents at a hospital with fever, he said, endocarditis is a rather uncommon cause. But, because many of these patients do not have the classic signs of the disease, and a physical examination may not reveal the cause of the illness, Dr Dubois said clinicians are relying increasingly on echocardiography even though it cannot always identify the infection causing the endocarditis.

A retrospective study was undertaken of 109 patients referred to the non-invasive cardiology laboratory of the hospital, who were IV drug users and had suspected infectious endocarditis. Twenty-four of these patients were later determined to have the disease.

A review of the charts of these patients and their clinical symptoms showed that all 24 of the endocarditis patients had one or both of two clinical signs which were among the 12 tabulated for each patient.

These two signs were bacteremia (the presence of bacteria in a blood sample), seen in 23 of the 24 patients with endocarditis, and a positive chest x-ray, defined as an x-ray showing multiple infiltrates or nodular densities compatible with emboli (clots) from the cuspid valve source, which was seen with 17 of the 24 patients. Only 16 of the 85 patients who turned out not to have the disease had either or both of these symptoms.

Dr Dubois said these findings indicate echocardiograms need only be performed in the smaller group of IV drug abusers who present with bacteremia and/or a positive x-ray.

"It must be realized that these guidelines apply to the routine case but not every case," he cautioned, stressing that echocardiograms should still be used with patients such as those with prolonged fever for which no other source can be identified, and for patients who had previously used antibiotics and therefore might have falsely negative blood cultures.

Inquisitive Prince Charles visits drug rehab centre

By Alan Massam

LONDON — Prince Charles, the Prince of Wales, has demonstrated his personal concern about the problem of drug addiction by visiting Britain's largest residential centre for people with drug problems.

The Prince saw staff and residents of the 150-bed Featherstone Lodge, a Phoenix House establishment set up in South London in 1970.

The centre is based on the Phoenix House philosophy established in New York City. Volunteer clients who promise to remain drug-free embark on a program of rehabilitation which seeks to restore their self-confidence and self esteem.

A spokesman said: "There are three crucial rules: no drugs, no alcohol, and no violence. But, rehabilitation is not a passive process, so perhaps a fourth rule should read —that everybody will make a contribution toward his or her own recovery and that of fellow residents.

"Considerable emphasis is placed on eventual re-entry into society. For the first few months of their stay, residents use a smaller satellite house, Battle Cottage.

There are currently 53 residents at Featherstone Lodge and 12 at Battle Cottage. The centre is run by Peter Martin and a staff of 12. They claim residents who stay on the program achieve a 90% recovery rate.

Prince Charles: concern

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

What Are You Going To Do about Alcohol?

Number: 639.
Subject heading: Alcohol/alcoholism overview, alcohol and youth.
Details: two - 10 min filmstrips, audio cassette.

Synopsis: In the first filmstrip, a man with a painted clown face discusses how alcohol works on the central nervous system, and pantomimes the effects of different amounts of alcohol. He describes different styles of drinking, and suggests where one can get help for drinking problems. The second filmstrip shows three situations and asks the audience to discuss each one: (1) Ed being asked to sneak some alcohol to bring to a party with his friends; (2) Shelly pushing Lou Ann into drinking some beer; and (3) Josh insisting on driving home even though his friends try to stop him because he is intoxicated.

General evaluation: Fair to poor (2.9). The method of presentation was interesting and the vignettes in Part 2 could lead to some discussion. However, the filmstrips attempted to cover too much. These filmstrips, therefore, were not judged to be good teaching aids.

Recommended use: With a resource person, these filmstrips could be used with audiences 12 to 15 years old.

Pot or Not

Number: 641.
Subject heading: Cannabis.
Details: 15 min, videotape, color.

Synopsis: Wynne Stewart narrates this video about job safety and cannabis. Two workers are shown "smoking up." As their story unfolds, the narrator points out the dangers of cannabis use in the workplace. These dangers are emphasized when one worker starts a fire while "high."
General evaluation: Fair to poor (2.6). While this videotape had a clear message, the narrator's style of presentation seemed condescending. The "ranks" of the characters (as indicated by the color of their hard hats) appeared to be inaccurate — this could detract from the film's credibility.
Recommended use: With a resource person, this video could be used for general safety meetings.

Are You Calling Me a Drunk?

Number: 642.
Subject heading: Alcohol/alcoholism overview.
Details: 15 min, videotape, color.
Synopsis: Wynne Steward narrates this safety videotape about the hazards of alcohol consumption in the workplace. Drinking affects both vision and judgement and, therefore, drinkers are a hazard to the safety of others. A dramatization of workers' concerns, their efforts to help one coworker and his potentially disastrous mistake highlight many of the issues involved.
General evaluation: Poor (2.3). This videotape had a good safety message, however, most employee assistance programs (EAPs) discourage coworkers from getting involved in identification, diagnosis, confrontation, and treatment.
Recommended use: With a resource person, this videotape could be used for general safety meetings on the job.

Generic Drugs, What Are They?

Number: 644.
Subject heading: Prescription drugs.
Details: 20 min, videotape.
Synopsis: Prescription drugs in their generic form are often less expensive than brand-name drugs. But, many people do not know the meaning of the word "generic." They do not know what generic drugs are, or whether they can have a choice between generics and brand-name products. This video attempts to explain the present status of generic drugs, what they are, and how they are monitored.
General evaluation: Good to very good (4.5). This well-produced video had good information and was judged a good teaching aid. General broadcast was recommended.
Recommended use: Of benefit to general audiences.

Marijuana Alert

Number: 643.
Subject heading: Cannabis.
Details: 20 min, color.
Synopsis: Tests are performed to see if smoking marijuana affects the human body. The film indicates a person's athletic performance is reduced and he makes more mistakes on an auto simulator and in writing a test. Marijuana-exposed Rhesus monkeys have more stillbirths and higher infant mortality rates. And, changes in the human brain have been detected in marijuana smokers, the film says.
General evaluation: Poor (2.2). Because of the poorly controlled experiments, this film was judged a poor teaching aid.
Recommended use: None.

Epidemic: War on Drugs

Number: 650.
Subject heading: Community development.
Details: 15 min, color.

Synopsis: After presenting a series of statistics and incidents which show that, until recently, drug use was epidemic in the United States, the narrator interviews people who have been fighting back. There are also scenes from community programs, employee assistance programs, and the military to illustrate that it is possible to win the war on drugs.

General evaluation: Poor (2.3). This film was a series of clips from several other sources and really did not explain how to go about combatting drug use.

Recommended use: None.

This publication is indexed in

BIHEP
BIBLIOGRAPHIC INDEX OF HEALTH EDUCATION PERIODICALS

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:

a) Regular Line Rates	$1.09 line
b) Standard Units of Insertion	
1 Page (1,120 lines)	$1,000
½ Page (560 lines)	$500
¼ Page (280 lines)	$250

c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation: 27,318 (Canada, 21,412; USA, 1,907; Foreign, 386; Bulk, 3,613)
Media 2,254

Single Subscription Rates:
Ontano Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.

The Journal, 33 Russell St
Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

DEPARTMENT

New Books

by RON HALL

Occupational Alcoholism: An Annotated Bibliography

. . . by N. R. Kurtz; B. Googins; and W. Howard

The bibliography contains the citations and abstracts of 481 references dealing with occupational alcoholism. It is divided into 20 subject groupings of growing interest. The first category consists of articles that provide an overview of the field. The next three categories review the literature addressing the character and structure of occupational programs, including program description, program typologies, and manpower and staffing. Treatment is the subject of three categories and two focus on the role of supervisors. Special sections are devoted to women and occupational programs, the role of unions, and attitudes, education, and prevention. Fiscal considerations are divided into the costs of employee alcoholism, insurance provisions for treatment, and studies of prevalence and risk. Additional categories summarize studies of legal aspects, issues of marketing programs, and specific discussions of research and evaluation. The volume contains a category and author index.

(Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1, 1984. 218p. $15. ISBN 0-88868-101-1)

Directory of Canadian Transportation Safety Professionals, 1984

. . . edited by Katherine DeGenova and Catherine Blake

The main section of the directory contains an alphabetical listing, by surname, of transportation safety professionals in Canada. Each entry has a brief summary of relevant demographic information, current research activities, research interests, and references of publications. Indexes identify the professionals by province, organization, and current research activities. It was recognized that safety professionals are scattered nationwide and that a directory would aid in facilitating information exchange.

(Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1, 1984. 167p. $8. ISBN 0-88868-099-6)

Others books

Dual Addiction — Kreek, Mary Jeanne, and Stimmel, Barry (eds). Haworth Press, New York, 1984. Pharmacological issues in the treatment of concomitant alcoholism and drug abuse; mechanisms of drug interactions with alcohol; alcohol interactions with benzodiazepines and cocaine; opioid interactions with alcohol; clinical issues concerning alcoholic youthful narcotic abusers. 120p. Haworth Press, 28 E 22 St, New York, NY 10010. $22.95. ISBN 0-86656-318-0.

Alcohol and Disinhibition: Nature and Meaning of the Link — Room, Robin, and Collins, Gary (eds). United States National Institute on Alcohol Abuse and Alcoholism, (NIAAA), Rockville, 1983. NIAAA Research Monograph No 12; proceedings of a conference held February 11-13, 1981, in Berkeley/Oakland California, nature and locus of disinhibition; perspectives on disinhibition in US society; disinhibition and social control. 505p. US Government Printing Office, Washington, DC 20402. $7.

A Dictionary of Drug Abuse Terms and Terminology — Abel, Ernest L. Greenwood Press, Westport, 1984. Defines slang and formal terms pertaining to drugs, drug use, drug effects, legal enforcement of drug laws, and other related aspects of drug manufacturing, selling and use. 187p. Greenwood Press, 88 Post Rd W, Box 5007, Westport, CT 06881. $29.95 ISBN 0-313-24095-7.

Guidelines for Investigating Alcohol Problems and Developing Appropriate Responses —Rootman, Irving, and Moser, Joy. World Health Organization, Geneva, 1984. Detailed planning; gathering information; improving responses to alcohol problems; improving responses at a national level; monitoring, assessment, and adjustment of policies and programs. 120 p. Canadian Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, Ontario K1Z 8N8, ISBN 924-170081-5.

Cocaine: Pharmacology, Effects, and Treatment of Abuse — Grabowski, John (ed). United States Government Printing Office, Washington, 1984. United States National Institute on Drug Abuse. Research Monograph 50; introduction and overview; mechanisms of the reinforcing action of cocaine; pharmacology; assessment of the dependence potential; behavioral pharmacology; changing patterns of cocaine use; current and experimental treatments. 135p. US Government Printing Office, Washington, DC 20402.

Alcohol Dependence Scale (ADS) User's Guide — Skinner, Harvey A. and Horn, John L. 1984. Review of important developments regarding alcohol dependence; reliability and validity of the ADS 25-item questionnaire; instructions for administration, scoring, and interpretation of the ADS. 38p. Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1. User's Guide $14.25. Package of 25 Questionnaires $6.25. Specimen set of 25 Questionnaires and 1 User's Guide $15.

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Addictions Extravaganza — May 4-5, Regina, Saskatchewan. Information: Dennis Stafford, 177 North Cornwall, Regina, SK S4R 3A1.

Alcohol and the Family Workshop: Community Program Approaches —May 6-7, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation (ARF), 8 May St, Toronto, ON M4W 2Y1.

Children of Alcoholics: Bystanders at Risk — May 7, Peterborough, Ontario, May 8, Perth, Ontario. Information: Linton Heth, Peterborough Centre, ARF, 223 Aylmer St N, Ste 7, Peterborough, ON K9J 3K3, or Colleen Purdy, Perth Centre, ARF, 39 Drummond St, Perth, ON K7H 2J9.

Art as Applied to Medicine — May 9-11, Toronto, Ontario. Information: Nancy Joy, professor and chairman, University of Toronto, faculty of medicine, department of Art as Applied to Medicine, 256 McCaul St, Toronto, ON M5T 1W5.

Catholic Health Association of Canada Annual Convention — May 15-17, Banff, Alberta. Information: Catholic Health Association of Canada, 312 Daly St, Ottawa, ON K1N 6G7.

Alcohol, Other Drugs, and the Law Course — May 22-24, London, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

Alcohol and Drug Abuse — May 23-24, Saskatoon, Saskatchewan. Information: Continuing Medical Education, University of Saskatchewan, 408 Ellis Hall, Saskatoon, SK S7N 0W0.

Parent Resources Institute for Drug Education (PRIDE-CANADA INC) 1st Annual National Conference — May 30-June 1, Saskatoon, Saskatchewan. Information: Ruth Kell, Convenor, PRIDE-CANADA, Ste 111, Thorvaldson Bldg, college of pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

85th Annual Meeting of the Canadian Lung Association and the Annual Scientific Meetings of the Canadian Nurses' Respiratory Society, and the Physiotherapy Section of the Canadian Lung Association — June 2-5, Ottawa, Ontario. Information: A. Les McDonald, health education coordinator, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, ON K1P 5E7.

Medic Canada 85 — June 3-5, Toronto, Ontario. Information: Medic Expositions of Canada Inc, 67 Mowat Ave, Ste 242, Toronto, ON M6K 3E3.

Child Abuse Conference — June 13-14, Toronto, Ontario. Information: Ingrid Norrish, program manager, Professional and Management Development, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Canada Safety Council 17th Annual Conference — June 23-26, St John's, Newfoundland. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, Ontario K1G 3V4.

International Convention of Alcoholics Anonymous — July 4-7, Montreal, Quebec. Information: International Convention, Box 1985, Stn D, Buffalo, New York 14210.

Management II for Supervisors in the Health Care Setting — July 5, Toronto, Ontario. Information: Professional and Management Development, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

26th Annual Institute on Addiction Studies — July 14-19, Hamilton, Ontario. Information: Kathryn Irwin, course administrator, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer School for Addiction Studies — July 15-26, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, ARF, 8 May St, Toronto, ON M4W 2Y1.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-10, Calgary, Alberta. Information: Jan Skirrow, chairman, 34th ICAA Congress, AADAC, 6th fl, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

Canadian Addictions Foundation Annual General Meeting — Aug 5, Calgary, Alberta. Information: Leona Gallinger, Canadian Addictions Foundation, Pacific Plaza, Box 702, 10909 Jasper Ave, Edmonton, AB, T5J 3M9.

Royal College of Physicians and Surgeons of Canada — 54th Annual Meeting — Sept 9-12, Vancouver, British Columbia. Information: Royal College of Physicians and Surgeons of Canada, Robert A. Davis, coordinator, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

Annual Meeting of the Canadian Society of Forensic Science — Sept 20-27, Montreal, Quebec. Information: executive secretary, Canadian Society of Forensic Science, 2660 Southvale Cres, Ste 215, Ottawa, Ontario K1B 4W5.

Ontario Public Health Association 36th Annual Educational and Scientific Meeting — Sept 22-25, Toronto, Ontario. Information: Ontario Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, ON K1Z 8N8.

Input 85 — The 6th Biennial Canadian Conference on Employee Assistance Programs in the Workplace —Oct 27-30, Ottawa, Ontario. Information: Input 85 Headquarters, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Skill Training for Employee Assistance Personnel — Nov 17-21, Oakville, Ontario. Information: James Simon, Peel Centre, ARF, 39 Dundas St E, Ste 203, Mississauga, ON L5A 1V9.

United States

11th Annual School on Addiction Studies — May 6-10, Anchorage, Alaska. Information: Ken Duff or Cheryl Mann, Center for Alcohol and Addiction Studies, University of Alaska, 3211 Providence Dr, Anchorage, AK 99508.

Central Region Conference of the Association of Labor-Management Administrators and Consultants on Alcoholism (ALMACA) — May 7-10, St Louis, Missouri. Information: Della Kinsolving, c/o St Elizabeth Medical Center, 2100 Madison Ave, Granite City, Illinois 62040.

4th Conference on Alcoholism and the Family — May 22-26, Philadelphia, Pennsylvania. Information: The Caron Foundation, Box 277, Galen Hall Rd, Wernersville, PA 19565.

6th Annual National Conference on Employee Assistance Programming — June 3-6, Kansas City, Kansas. Information: Bethany Medical Center, The National EAP Conference, 51 North 12th St, Kansas City, KS 66102.

2nd Annual Summer Institute for Alcohol and Drug Studies — June 3-7, Evansville, Indiana. Information: Dr Nadine Coudret, coordinator, Institute of Alcohol and Drug Abuse Studies, University of Evansville, Evansville, IN 47702.

Committee on Problems of Drug Dependence 47th Annual Scientific Meeting — June 10-12, Baltimore, Maryland. Information: Dr Joseph Cochin, executive secretary, Committee on Problems of Drug Dependence, department of pharmacology, Boston University School of Medicine, 80 E Concord St, Boston, Massachusetts 02118.

16th Annual International Narcotic Research Conference — June 23-28, Seacrest, Massachusetts. Information: E. Leong Way, PhD, department of pharmacology, University of California, San Francisco, California 94143.

Rutgers Summer School of Alcohol Studies 1985 — June 23-July 12, Piscataway, New Jersey. Information: Gail Milgram, education and training division, The State University of New Jersey Rutgers, Center of Alcohol Studies, Smithers Hall, Piscataway, NJ 08854.

36th Annual Symposium on Alcoholism — June 24-July 5, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, Seattle, WA 98122.

14th Annual San Diego Summer Alcohol and Drug Studies Program — July 8-12, La Jolla, California. Information: P.A. Moore, UCSD Extension, X-001, La Jolla, CA 92093.

New Jersey Summer School of Alcohol and Drug Studies — July 28-Aug 2, Piscataway, New Jersey. Information: Gail Milgram, education and training division, The State University of New Jersey Rutgers, Center of Alcohol Studies, Smithers Hall, Piscataway, NJ 08854.

36th Annual Conference of the Alcohol and Drug Problems Association of North America — "Confronting the Issues — Challenges for the 80s" — Aug 18-21, Washington, DC. Information: Eric Scharf, ADPA, 444 N Capitol St, Ste 181, Washington, DC 20001.

National Federation of Parents for Drug-Free Youth, 4th Annual Conference — Nov 6-9, Washington, DC. Information: Mary Jo Green, NFP, 1820 Franwall Ave, Ste 16, Silver Spring, Maryland 20902.

Association of Labor-Management Administrators and Consultants on Alcoholism, 14th Annual Conference — Nov 10-14, Boston, Massachusetts. Information: Judith Evans, associate director, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

Association for Medical Education and Research in Substance Abuse, 9th Annual Conference — Nov 14-15, Washington, DC. Information: Dr G. Lewis, AMERSA president, Center for Alcohol Studies, Brown University, Box G, Providence, Rhode Island 02912.

Abroad

Drinking and Driving: The Role of the Alcoholic Beverage Industry — May 27-29, Rome, Italy. Information: Frank A. Haight, Pennsylvania Transportation Institute, Pennsylvania State University, Research Bldg B, University Park, Pennsylvania 16802.

10th Congress of the International Association for Accident and Traffic Medicine (IAATM) — May 27-31, Tokyo, Japan. Information: 10th Congress of the IAATM, Secretariat, International Congress Service, Inc, Chikusen Bldg 5F, Nihonbashi 2-7-4, Chuo-ku, Tokyo 103, Japan.

31st International Institute on the Prevention and Treatment of Alcoholism — June 2-7, Rome, Italy. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

International Youth Forum on Alcohol and Drugs — July 9-12, Cardiff, United Kingdom. Information: Myrddin Evans, Addiction Unit, South Glamorgan Health Authority, Whitchurch Hospital, Whitchurch, Cardiff, CF4 7XB, UK.

1985 World Congress on Mental Health — July 14-19, Brighton, England. Information: Barbara Poole, World Congress organizer, 22 Harley St, London, England W1N 2Ed.

15th Biennial Caribbean Federation for Mental Health Conference — July 21-26, New Providence, Bahamas. Information: The Bahamas Mental Health Association, PO Box N-7531, Nassau, Bahamas.

3rd International Conference on Alcohol and Drug Abuse — Aug 11-14, Lima, Peru. Information: L. Vasquez, International Education, Peruvian College of Physicians, Wadsworth, Illinois 60083.

2nd National Drug Institute — Alcohol and Drug Use in a Changing Society — Aug 14-16, Darwin, Northern Territory, Australia. Information: chairman, NDI Planning Committee, Drug and Alcohol Bureau, Northern Territory department of health, GPO Box 1701, Darwin NT 5794 Australia.

European Congress on Prevention of Alcoholism and Other Drug Dependencies — Sept 30-Oct 4, Opatija, Yugoslavia. Information: International Commission for the Prevention of Alcoholism and Drug Dependencies, Non-governmental Organization of the United Nations, 6330 Laurel St, NW, Washington, DC 20012.

Vol. 13 No. 10 — TORONTO October 1, 1984

The Journal

Published monthly by Addiction Research Foundation — WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Government faces opposing recommendations

MDs clash in heroin as medicine debate

By Anne MacLennan and Betty Lawler

TORONTO — As Canada's new Progressive Conservative government settles into leadership, the future is uncertain for two strong but apparently conflicting recommendations to government on the use of heroin as medicine.

Federal drug bureaucrats who've operated almost exclusively under the Liberal party for more than 20 years, are of one mind directions voice what happens to the recommendations is up to government.

Appearing slightly less vulnerable to political winds because now entrenched in the system, is another and separate Liberal government initiative from last year — clinical trials to compare pain relief from heroin and other narcotic drugs such as morphine and Dilaudid (hydromorphone) in cancer patients.

The protocol is almost complete and the trials should be ready to go by late autumn, Denys Cook, Phil director general of Health and Welfare's Drug Directorate, told The Journal. He says his office is proceeding on the assumption they'll be going ahead. They're expected to take about two years.

For now, government faces one recommendation from the 38,000-strong Canadian Medical Association (CMA) that calls for removal of the 30-year ban on prescribing heroin for medicinal purposes.

In an annual meeting debate that had almost as much political as medical content, the vote wasn't even close enough to require a standing count, in spite of predictions it could go either way. This runs counter to the position of the American Medical Association which in a similar debate in the United States (The Journal, May 1) has now said there is no medical need to reintroduce medical use of heroin.

(Says Jacques LeCavalier, director of Canada's Bureau of Dangerous Drugs, what is commonly referred to here as the ban on heroin is specifically a ban on importation of heroin. It stems from a 1954 health ministers policy decision to disallow importation of heroin. All that is needed to change that he says is a new policy decision. Low importance of permits to drug companies wishing to import and distribute the drug for medical purposes.)

The other recommendation [illegible] heroin [illegible] cancer patients has been made for the past two years by medical columnist Dr. Kenneth Walker of Niagara Falls. But there's been relatively little mention of it since.

There was more talk of how [illegible] had been misled 30 years ago into thinking the CMA supported the ban, how heroin addiction a medical condition had been criminalized and how doctors were being told by politicians how they can practice medicine.

Obviously delighted with the vote, William Uberoi, professor of surgery at Queen's University, Kingston, predicted quick action by the new federal government. (See — Heroin — page 2)

Begin — Sellers — Ghent

Whatever the causes of [illegible] medical care, clinical experience and the medical literature are remarkably consistent in their judgement that treatment failures occur and that most such failures are preventable.

Their recommendation for [illegible] giving each [illegible] medical nurse and extra medical personnel [illegible] researchers and [illegible] nurses.

In the CMA debate, although a well-publicized and emotional appeal for the use of heroin for terminal cancer patients has been made for the past two years by medical columnist Dr. Kenneth Walker of Niagara Falls, the vote was relatively little mention of it since.

There was more talk of how [illegible] had been misled 30 years ago into thinking the CMA supported the ban, how heroin addiction a medical condition had been criminalized and how doctors were being told by politicians how they can practice medicine.

Obviously delighted with the vote, William Uberoi, professor of surgery at Queen's University, Kingston, predicted quick action by the new federal government. (See — Heroin — page 2)

PCP resurgence, cocaine tabs confounding US drug experts

By Harvey McConnell

WASHINGTON — A major resurgence of phencyclidine (PCP) use in several United States cities and the appearance of cocaine-loaded gelatin tablets intended for young people are two major [illegible] US drug abuse officials.

[illegible] director of [illegible] Institute on Drug Abuse (NIDA), [illegible] Drug Problems Association of North America that Washington, Los Angeles and New York are among the cities where PCP use is again rampant.

The majority of admissions in the past five months to St Elizabeth's, the federal mental hospital in the District of Columbia, have been because of acute psychotic episodes related to PCP use.

"The drug was found in 65 people who died traumatic deaths in 1983 District of Columbia officials have said compared with 15 in 1982. Al[illegible]

though known nationally as [illegible] get dust in Washington it is [illegible] called also "the key to St E[illegible]" Hinckley, because one of his patients at the hospital is John Hinckley, who shot President Reagan.

The [illegible] explanation for [illegible] outbreaks of PCP use, Dr Pollin said, is to find any of the social or cultural factors that can explain in any conceptual way why these kinds of outbreaks with different drugs occur specifically. When they do occur and they will continue to occur.

Dr Pollin later noted that PCP-like inhalants can give users the biggest bang for the buck, and economic factors could play a part in the use of such drugs.

As for cocaine he said a most disturbing factor is that we are hearing of a new pattern of distribution of gelatin capsules filled with cocaine and selling for about $10 a capsule. There could be a whole new range of users in school-age kids.

In some parts of the country, the price of cocaine has dropped to about $60 a gram.

As for [illegible] Weston knows [illegible] the continued increase in clinical problems associated with cocaine represents the [illegible] table five-year-later [illegible] of the substance [illegible] marijuana use [illegible] 1980 or another it represents a break through regarding prevalence into a really new expansion of cocaine use.

The idea that this is a predictable late stage sequence of peak marijuana use is consistent with studies which have shown the best single predictor of heavy cocaine use among people in their twenties is heavy early marijuana use. Other studies have shown a five year gap between the first use of cocaine and the appearance of serious medical problems.

Children of alcohol: generation at risk

By Maureen Brosnahan

WINNIPEG — Children of alcoholics need to be identified and provided with early counselling because they run a high risk of becoming alcoholics themselves in later life, says a psychiatry professor at the University of Manitoba.

Nady el-Guebaly said numerous studies show that a child whose father was alcoholic has four times greater risk of developing a drinking problem than a child of a non-alcoholic parent.

As well children whose mothers are alcoholics are also at risk both physically and emotionally, he told the Issues in Chemical Dependency Conference here.

While cases of this are less frequent, "the impact is much more severe on the children," Dr el-Guebaly said.

He said in Manitoba alone there are more than 10,000 children at risk. These are the children of the roll started 5% to 10% of the popula[illegible]tion who are alcoholic in the province.

Dr el-Guebaly said such children need to be identified and offered counselling. "Kids of chemically dependent parents have a lot of problems. Kids of chemically dependent parents need a lot of help.

Although he said not every child would need intensive counselling, they all have and need to be told they aren't to blame for their parents' addictions.

Families and alcohol — A legacy of love and pain p C1-C4

INSIDE

Pope John Paul II urges kids to resist drinking, drugs p2

Caffeine: history, habits, and health p5

Canadian doctors grappling with addiction p7

WHO plan aims to sober up Europe p10

Unemployment: key to Britain's heroin woes? The Back Page

Keep it up!

subscribe

Canada	$16/yr
USA & Foreign	$24/yr
Microfiche	$18/yr
Air Mail	add $19/yr

(Please prepay)

The Journal Marketing Services, Addiction Research Foundation Dept KMM, 33 Russell Street, Toronto, Canada M5S 2S1.

Name _____

Address _____

_____

Celebration of drinking obscures alcohol's potential

TV programs equate alcohol with good life

By Alan Massam

LONDON — Health educators concerned about the impact of television advertising of alcohol products should also consider the content of the TV programs themselves.

That is the message from Anders Hansen, a research fellow at the Centre for Mass Communication Research, University of Leicester.

Mr Hansen told a meeting called by the Institute of Alcohol Studies at the Independent Broadcasting Authority's offices here, that commercial advertising accounts for a relatively small proportion of the overall stream of alcohol images to which the viewer is exposed.

Mr Hansen reported a study based on the assumption that images of alcohol on television programs (whether news, current affairs, documentaries, or entertainment) may have implications equal to, or greater than, the images of alcohol in advertising.

His observations were based on a systematic content analysis of two weeks of prime-time television broadcast on all four channels in the United Kingdom. The analysis set out to establish:

1. How much portrayal of alcohol is there in fiction and non-fiction programs?
2. How much portrayal is there of the potentially negative effects and consequences of alcohol use and abuse?
3. Who is shown drinking what, where, and in what context?

Mr Hansen said the study found that visual or verbal references to alcohol occurred in about two-thirds of all prime-time programs, while actual consumption of alcohol was shown in just less than one-third of them.

Three scenes an hour

Fictional programs were clearly the main source of alcohol images with reference to the drug appearing in 87.7% (with 71.7% showing actual consumption of alcohol). In comparison, actual consumption occurred in only 11.2% of non-fictional programs, and there were visual or verbal references in slightly more than half of them.

A more-detailed, quantitative measure of the extent of alcohol portrayal was, Mr Hansen said, the rate of drinking scenes per hour.

On average, a scene showing one or more characters consuming alcohol occurred 1.6 times per hour. But, in fictional programs, there was an average 3.4 drinking scenes per hour. This meant that a viewer who watched Coronation Street, Brookside, Dallas, Crossroads, or Play for Today would, on average, encounter more than three separate scenes per hour showing characters drinking alcohol.

Mr Hansen said it was clear that fictional programs were the main source of alcohol and drinking images, but further observation showed that there were few references to its potentially negative consequences.

Despite the prominence of accident and crime reporting on news magazine programs, for example, the serious role often played by alcohol and excessive drinking in relation to accidents, violence, and crime was rarely mentioned.

Lighthearted references

The portrayal of alcohol in news magazine programs was typically related, in fact, to a celebration of one sort or another. Typically, a group of people would be shown toasting with champagne to celebrate a new project or sports victory. There was some suggestion that drinking in these programs was generally for celebration and so was associated with initiative, entrepreneurship, victories, and achievement.

The same general conclusion could be drawn from fictional programs. Despite the prominence of drinking scenes, alcohol consumption was rarely shown to have any adverse or serious effects. Intoxication was the effect most often referred to, and while this kind of portrayal was predominantly serious, there were a substantial number of lighthearted and comic references.

Coronation Street: fictional programs feature 3.4 drinking scenes per hour

Mr Hansen: "There are very few portrayals of alcohol consumption with more specific outcomes, such as assaults, car accidents, fires, homicides, family abuse, or ill health."

He added that the depiction of excessive drinking played a clear narrative function by adding to the complexity and suspense of TV plots, but this use does not appear to be particularly conducive to learning about the real-life role of alcohol in relation to accidents, crime, and violence.

Double standard

"It seems possible that these portrayals of alcohol help foster and sustain the double standards found in real life with regard to drinking and driving, drinking and work, and drinking and violence, and so on," he said.

"The relative absence of portrayals of the potentially negative and harmful effects of alcohol suggests that alcohol is shown as an essentially unproblematic aspect of the lives of the characters who populate the world of television fiction."

This suggestion was confirmed by an analysis of the characteristics of drinking characters. This showed that, in fictional programs, drinking was a predominantly male activity with male drinkers outnumbering female drinkers 2.5 to 1.

A breakdown of the ages of television drinkers found that 45.5% were in the 25 to 44 age group, 38% in the 45 to 64 age group, and 13% less than age 25.

This was particularly interesting because the code governing advertising on television (the IBA Code of Advertising Standards and Practice) states that "no one associated with drinking in an advertisement should seem to be younger than about 25."

Another interesting observation to emerge from the research was the heavy bias toward the higher echelons of society in the distribution of drinkers across the social classes. Three-quarters of the drinkers belonged to the middle or upper-middle classes, while a mere one-quarter were portrayed as working class.

This suggests that drinking on television is associated with the lifestyles of the rich and well-off considerably more often than with the lifestyles of those at the other end of the social scale.

The bias toward affluence was further suggested by the social milieu in which alcohol was consumed. While 62.4% of drinking occurred in what might be described as ordinary places, about one-third occurred in luxurious or rich milieux. Less than 5% of television drinkers consumed alcohol in poor or destitute environments. The analysis thus showed that alcohol consumption on TV was associated with an affluent lifestyle.

Reinforces beliefs

Mr Hansen also claimed the study showed that although a sizeable minority of TV drinkers were seen drinking at work, there was no portrayal of alcohol-related work accidents; that television drinkers were stereotyped as to their choice of drink suggesting that the medium may contribute to beliefs about the different social values of wines, spirits, and beer; and that TV drinkers seldom drink alone.

He said the research indicated more study is needed to examine the extent to which television cultivates and reinforces beliefs that: alcohol consumption is the norm rather than the exception in social interaction; that alcohol consumption is a mark of an affluent lifestyle; and that alcohol consumption rarely contributes to accidents, violence, or ill health.

THE BACK PAGE

Vol. 14 No. 6 2nd Class Mail Reg No 2776 TORONTO June 1, 1985

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Nancy Reagan: An emotional farewell to the 3,000 parents and young people at this year's PRIDE conference in Atlanta — the conference of the 'first ladies.' See also pages 3 and 16.

US parents plan international move against drug use

By Anne MacLennan

ATLANTA — The high-powered United States parent movement against drugs wants to take on the world — building a global network of interested parents and stretching from there.

Says Marsha Manatt Schuchard, PhD, one of the movement's founders: "What we've seen all over is that big plans waste people's time. So, we're trying to work out an international communications network where we know the people and where they are, and we can exchange useful information. Letter-writing can help."

The US groups believe they have something to offer parents in other countries, including Canada.

Thomas J. Gleaton, Jr, EdD, is executive director and co-founder with Dr Schuchard of PRIDE (Parents' Resource Institute for Drug Education, Inc), a listening post and information centre for parents. It grew out of Dr Gleaton's work with young people at Georgia State University. Dr Schuchard is volunteer research director.

Says Dr Gleaton: "In talking with parents and youth around the world, American (US) parents active in the anti-drug movement experience a sad sense of *déjà vu*: 'We've already been where you're just arriving.'

"It is our hope that newly-stricken countries can learn from our mistakes and from our beginning signs of success," he says, referring chiefly to the levelling off of drug use among US teens (**The Journal**, March) —for which the parent groups are both taking and being given some credit.

But, there are other "signs of success."

The movement began less than a decade ago, over backyard fences and on kitchen telephones. The first meeting was "20 mothers and 80 experts, most of them angry that we'd invited mothers," Dr Schuchard told **The Journal**.

Today, there are between 8,000 and 9,000 parent groups across the US, with uncounted thousands of members, loosely linked under the umbrella, and lobbying, National Federation of Parents for Drug Free Youth. Formed in 1980, it is based in Washington, close to the politicians.

At this year's meeting here at the end of April — the PRIDE International Conference on Drugs 1985 — there were 3,000 parents

(See — Drugs — page 3)

Study links drugs with suicidal kids

By Betty Lou Lee

TORONTO — The majority of young people who kill themselves have a long history of alcohol and other drug abuse, a San Diego study has shown.

Of 133 suicides under 30 years studied, 88 had drug, and 72 alcohol disorders. Many had both. Of 150 suicides more than 30 years, 82 had alcohol disorders, but only 39 had other drug problems.

Charles Rich, assistant professor of psychiatry, University of California, San Diego, said alcohol and drug abuse have been recognized factors in suicide, but this is the first study based on hard data. The large number of drug abusers, especially among the young, has not been reported before.

His colleague Richard Fowler, said: "If we're going to lower the suicide rate in the young, we have to treat alcohol and drug disorders early."

They presented their results at the 18th annual meeting of the American Association of Suicidology. Their data were drawn from interviews with survivors, professionals, hospital and coroner records, and from 258 toxicology reports, some of which contained 50 drug screens.

See — Family ills — page 4

Dr Rich said since the San Diego suicide rate was close to the United States national average (13.1 vs 11.9 per 100,000), the findings probably have wider applicability.

The young suicides started using drugs at an average age of 15 years, and used them nine years before their deaths. Only 16% of them used drugs or poisons to kill themselves, compared to 24% of the older group.

Half of each group shot themselves.

Only two of the young abusers used only alcohol, and most were involved with three or four substances.

Rejection and separation were prime factors for 43 young people, but they were not without support systems, Dr Rich said. While they were less likely to be married than the older group, only 8% were living alone. They had no higher frequency of broken families or child abuse than the general population.

Unemployment and job or school problems were not significant triggers in either group, but the older cases were more likely to have some physical disorder, and for 28 of them, illness was a triggering factor.

While there has been a great deal of attention focused on adolescent suicide, Dr Fowler said it was important to note that teenagers aren't the biggest problem; early adults are. Only 13 males and one female under 20 years were among the 133 suicides under 30.

The frequency of specific substance abuse disorders in the young reflected the national US popularity of various drugs: cannabis, 59%; alcohol, 43%; cocaine, 32%; amphetamines, 24%; hallucinogens, 23%; and sedatives/hypnotics, 19%.

Dr Fowler said many abusers were supported and protected by schools and parents during their teens. "It doesn't hit them until their 20s, but alcohol and drug abuse are progressive disorders, and the situation gets worse with time. The big problem with adolescent abusers is recognizing them early and getting help, even though they are often objecting that they have no problem."

Real work in health, education still missing

July conference ends UN women's decade

By Joan Hollobon

TORONTO — The United Nations (UN) Decade for Women has helped increase international awareness of women's issues — including problems related to alcohol, tobacco, and other drug use.

But, the real health and education work remains to be done, says Sharon Gray, executive director of MATCH International Centre, a Canadian, non-governmental organization (NGO) born with the decade.

"Most countries, including poor countries, have established women's bureaus . . . but the actual work in the health and education field has yet to be done," she told **The Journal** in a telephone interview from Ottawa.

The decade winds down in Nairobi, Kenya in July at the UN World Conference to Review and Appraise the Achievements of the decade, July 21 to 26, and the NGO Forum, July 10 to 19.

Canada will be well represented.

Secretary of State Walter McLean, whose portfolio includes Status of Women Canada, is expected to lead the official delegation to the governmental conference. Canada will also be a part of the Commonwealth Ministers' meeting, July 13 — the first ever to focus exclusively on women's issues. And, Canadian groups, including MATCH, will participate in the NGO forum.

Ms Gray's organization, MATCH, links resources of women in Canada with the self-identified needs of women in The Third World, to help them carry out local development projects. It was created in 1976 as a direct result of the International Women's Year Conference in Mexico City, in 1975, and has supported projects related

(See — Abuse — page 2)

INSIDE

NEWS

Briefly...

Synthetic drugs legal

LOS ANGELES — Slight changes in the molecular structure of synthetic heroin and other "designer drugs" being produced in sophisticated underground labs in California keep them technically legal and frustrate police attempts at control, *Reuters News Agency* reports. Health officials here say the potent and deadly drugs could eventually make the poppy fields of Asia and South America obsolete. An estimated 20% of California heroin addicts already use the synthetic variety, says Robert Roberston, MD, of the state Division of Drug Programs.

Tobacco board fight

OTTAWA — A heated debate on whether Canada needs a national tobacco marketing board has anti-smoking groups squared off against tobacco growers, *Canadian Press* says. Growers asked the National Farm Products Marketing Board hearing their request not to allow comment from anti-smoking groups. The council ruled it will hear briefs from all interested parties. Many medical and consumer groups opposed to the marketing board idea have already made strong submissions against such an agency. It is expected hearings will now be held in several cities.

More Canadians drink

TORONTO — A Gallup poll released here in April indicates the number of Canadians using alcohol is increasing. *The Toronto Star* reports 82% of those interviewed said they drink, compared to 59% who said so in 1943, the first time such a survey was conducted. The younger generation is the most-accustomed to alcohol, with 90% aged 18 to 19 years drinking liquor, beer, or wine. The survey shows 86% aged 30 to 49 years drink, while 70% more than 50 years do.

Toxic torts

WASHINGTON — United States lawyers are using a new weapon in their campaign against tobacco companies, *The Medical Post* reports. "Toxic torts," explained John Banzhalt, director of an activist agency called Action for Smoking and Health, are wrongs based on a toxicity to an individual. He said there are 25 lawsuits pending in US courts on behalf of families of individuals who died as a result of smoking. Suits against companies manufacturing asbestos have succeeded using the "toxic tort" principle.

Anesthetic lollipops

UTAH — University of Utah doctors are experimenting with anesthetic-spiked lollipops to avoid frightening children with hypodermic needles, the *Medical News* reports. As a pre-operative, the lollipop makes the patient sleepy and produces a warm sensation like being in a warm bath. The university is testing the device on 20 volunteers.

They see substance abuse differently

US students downplay alcohol risks

By Harvey McConnell

WASHINGTON — Many young people in the United States are underestimating the dangers of regular alcohol consumption, says Lloyd Johnston, PhD, director of the annual US survey of drug use among high school seniors.

The evidence is that young people have an extremely high level of alcohol consumption in absolute terms; and certain patterns of use, like daily drinking, heavy party drinking, and driving while drunk, are troublesomely high.

Allied with this is a vigorous effort by beverage companies to stem a decline in sales, and which comes under criticism for what Dr Johnston considers present aggressive advertising.

Since 1975, Dr Johnston, of the Institute for Social Research, University of Michigan, Ann Arbor, has carried out yearly studies on some 17,000 seniors in 140 public and private high schools.

He told the annual conference of the National Council on Alcoholism here that despite the slight downturn in overall alcohol prevalence they have reported in the last couple of years, the proportion of seniors using alcohol for certain motives has continued to increase.

The number using alcohol "to get away from my problems" has risen to 18% from 12% among high school seniors over the years since 1975. The proportion who use alcohol to deal with anger and frustration has risen to 16% from 11%.

At least 30% of the seniors indicated that in the two weeks prior to the survey they had been driving after consuming alcohol, and roughly 45% had been passengers in cars where the driver had been drinking. About 18% drove after consuming five or more drinks in a row, "which means, in other words, that they were certainly drunk," Dr Johnston added.

Dr Johnston said that clearly "a lot of our kids are at risk of drunk-driving problems. There hasn't been a great deal of change in that, in my opinion, in the last few years, despite our considerable efforts."

Beer is far and away the most popular beverage, from those who report they drink every day to those who report they drink heavily at parties.

Dr Johnston suggested: "We are now at a peak level in terms of alcohol consumption by our young people."

He pointed out there are some contradictions; a majority believe substance abuse is harmful physically or psychologically, and this is particularly true in the case of marijuana. Those who think regular marijuana use is dangerous rose to two-thirds from one-third of all seniors between 1978 and 1984 while daily use by seniors dropped to 5% from 11%.

But, young people look at alcohol in a different light: about 80% think there is not a great risk involved in one or two drinks a day. As for party drinking (five or more on one occasion), a majority (up to two-thirds in some schools) think there is no great risk.

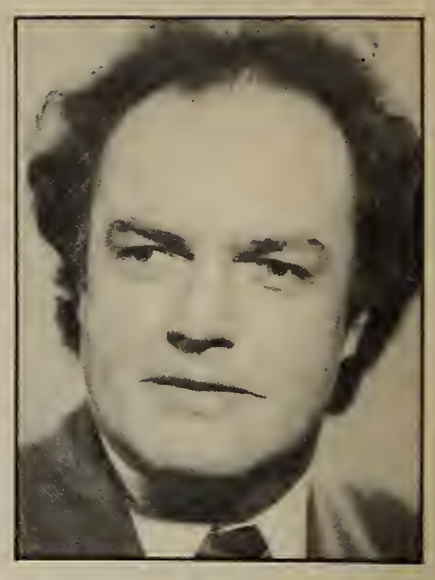
Any objective assessment would be that many young people are underestimating the dangers associated with these patterns of regular alcohol consumption. More needs to be done to make them appreciate the dangers of heavy alcohol consumption.

Dr Johnston said seniors believe nearly all their friends would disapprove if they took four or five drinks a day, but only about 50% would object to their drinking that on the weekends. Some 30% said most or all of their friends do get drunk every week.

Except in the extreme forms of drinking, "drinking peer norms are not acting as a restraint for use in a large proportion of the students," Dr Johnston said.

Turning to presentation of alcohol in the media, Dr Johnston said it is his impression that "those who write and produce the shows for media are, in fact, making a genuine effort to act with more self-awareness and a greater sense of social responsibility in how they portray alcohol consumption in their programming."

But, Dr Johnston continued, "as to the advertisers, particularly the beer companies and their direct beneficiary, the broadcast companies, it is my impression they are working furiously to give the appearance of social responsibility by toning down their ads and issuing a plethora of public service announcements during the period when restrictive legislation is being considered by Congress."



Johnston: disturbing

Abuse problems unhappy link for women

(from page 1)

to health, because women are closely involved in health through concern for reproductive safety and children's needs, said Ms Gray.

Equality, peace, and development are the declared themes of the UN Decade.

Ms Gray explained that a decade ago the role of women in development was not much thought of, despite the fact women in developing countries frequently carry major responsibility for family survival, such as growing food, transporting water, providing fuel. It is beginning to be recognized now, she said, that development projects brought in from the developed countries that ignore such traditional roles can fail, or become disruptive.

Another Canadian involved in the July Nairobi conferences is Freda Paltiel, senior adviser on the status of women to the National Department of Health and Welfare. She will focus on women's health problems.

John Osborne, special adviser on policy development in the department, told **The Journal** in an interview Ms Paltiel has attended meetings in Vienna during the past three or four years in preparation for Nairobi. Last month, she participated in final planning sessions in New York City.

Mr Osborne said the federal health department is also sending representatives of the Canadian Nurses Association to the NGO Forum.

Throughout the world, drugs, alcohol, and tobacco are increasingly becoming an unhappy link among women, with those in the developing countries beginning to emulate their sisters in the 'advanced' nations.

For example, two years ago in Winnipeg, Mira Aghi, a behavioral scientist from Bombay, told the Fifth World Conference on Smoking and Health that cigarette smoking is slowly gaining a foothold among young women in India, particularly women working in international companies, "who identify themselves with their counterparts in the Western World." Rural women, among whom oral cancer is frequently encountered, use other forms of tobacco.

Cultural changes are also bringing East and West closer. Alcohol drinking among Japanese women, once unheard of, is increasing so that "kitchen drinkers" who become alcoholics in their 30s and 40s are no longer rare. These women drink secretly, like many in the Western world, to avoid loneliness when husbands and children are away during the day (**The Journal**, April, 1978).

The economics of drugs also concern women: women are directly affected by deforestation and the reduction of food crops in African countries, when land is converted to tobacco for quick cash profit (**The Journal**, October, 1981). This policy creates fuel as well as food shortages.

The World Health Organization (WHO) estimated last year that 590,000 new cases of lung cancer and more than one million premature deaths each ear, "an increasing proportion of them in developing countries," are due to cigarette smoking (**The Journal**, June, 1984).

In the West, men are beginning to smoke less while women are smoking more. In developing countries, it is mostly men who smoke, except in Hong Kong and Singapore, where the WHO reported death rates among women, "among the highest in the world." The premature deaths of Third World men often mean destitution for their wives and families.

In the Western world, particularly North America, illicit drug abuse, especially the rising use of cocaine, is of increasing concern. In developing countries, easily-available psychotropic drugs, particularly benzodiazepines, allow widespread abuse and dependency.

If the Nairobi conferences address the severe effects on the health and well-being of women that drugs, alcohol, and tobacco are having, much can be done to expedite the work.

Doctors warned to keep pace with change

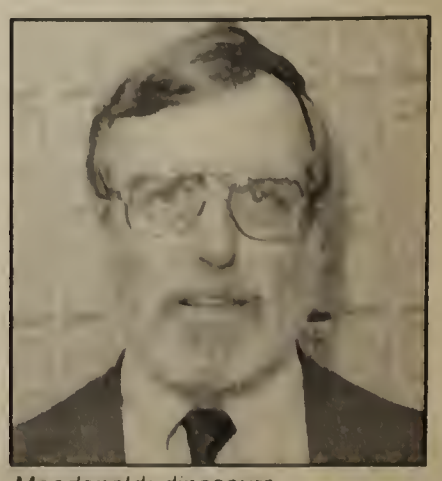
WASHINGTON — The day of collaboration between the medical and lay communities in the substance abuse field has arrived, whether doctors like it or not, says Ian Macdonald, director of the United States Alcohol, Drug Abuse, and Mental Health Administration.

"Those who refuse to see it are going to be dinosaurs," he told the American Medical Society on Alcoholism meeting here.

"When we talk about the issues of giving up some of what we control in the medical system, or used to control, or feel we should control, we have to be very careful that we separate out openness from turf battles," Dr Macdonald said.

"We have to be aware of the fact that our scientific scepticism is often well warranted, but it must not be confused with protection of a system we are not as sure of as we ought to be. It is a new field we are in, and things are changing rapidly."

Dr Macdonald said medical schools are finding it very easy to teach the cognitive side of alcohol and other drug abuse, but find it very difficult to change attitudes.



Macdonald: dinosaurs

PARENTS

Anne MacLennan reports from the PRIDE International Conference on Drug Abuse in Atlanta

Canada needs more student data, more treatment

ATLANTA — There's no tally yet of the number of parent groups against drugs in Canada.

But they're springing up across the country, says Eloise Opheim, executive director and co-founder of PRIDE CANADA, and president of the PRIDE chapter in Saskatoon.

"The problem is our country is too big," she told **The Journal** here. "And there's nobody to bring them all together."

There are, however, known groups in every province, including Saskatchewan, where drug problems among rural teens are equal to or worse than among urban teens.

She said while there are good data on teen drug use in Ontario, collected by the Addiction Research Foundation, there is not enough information on a country-wide basis.

"If we're going to have prevention strategies, we have to have something like what is being done each year at the University of Michigan," she said, referring to the United States national student surveys carried out by Lloyd Johnston (see page 3).

She also commented on the lack of treatment facilities for young people in Canada, particularly in the western provinces, and the fact young people from there tend to go to the US for treatment.

"Why should we send our kids three hours flying time away? It's as costly to send them to Montreal, for example, and Montreal is farther away."

Doctors are frustrated too, she said. "We have doctors who don't know where to send kids."

Mrs Opheim, whose organization is modelled after, and works closely with, PRIDE in the US, was in Atlanta for the PRIDE International Conference on Drugs 1985.

At that time, she said there were about 140 people registered for the PRIDE CANADA meeting at the University of Saskatchewan, Saskatoon, about a week ago.

The meeting was to include several speakers from the US parent movement — the "road show" as Dr Marsha Manatt Schuchard, co-founder of the US PRIDE, puts it. (PRIDE office, University of Saskatchewan, (306) 343-1100).

Opheim: three hours away

But, they must guard against naivety

Parents are in best place to give help: Schuchard

ATLANTA — The best drug abuse prevention can and should be done by parents and young people at the community level, says one of the founding members of the still-growing parent movement against drugs in the United States.

"After a lot of terrible mistakes in this country — wasted time, wasted money, wasted lives — we're finding that ordinary people figure out best how to get prevention working in their own communities," Marsha Manatt Schuchard, PhD, said here.

"The role of government is very clear; it may be slightly different in different countries, but government is not responsible for raising your children.

"And that's the message of this whole thing: that we've got to find methods to reach the people who are responsible for raising and caring about children."

She said support of governments, or "first ladies," or prime ministers can be "a tremendous help." But, "even if they don't care, even if they don't like what you're doing, you can get the job done in your own community, because only the people who directly affect children — their parents, their friends, their teachers, their coaches — really have much influence on them."

Dr Schuchard noted, however, that parents must beware of being "naive and uninformed about the reality of slang, of marketing, of everything that's out there." She calls it "reality education."

"What we all owe our children, all over the world, and what we owe ourselves as parents, is a much more informed and active refusal to accept the commercial forces that look upon these vulnerable 12, 13, 14, and 15 year olds as consumers, of whom any manipulation is allowed by the society they grow up in."

While the particulars may differ from country to country, young people around the world are getting the messages of a drug-taking, drinking, hedonistic, pleasure-seeking culture.

Schuchard: reality of slang

She warned delegates from other countries: "American parents had to learn the hard way in the late 1970s that a commercialized drug culture had grown up right under our noses — a culture that used the sophisticated techniques of modern marketing, advertising, and salesmanship to make illegal drug use seem fun, fashionable, normal, and inevitable. While more and more adolescents came to believe that 'everybody does it,' most parents still believed that 'nobody does it,' especially 'not my kids.' "

It is the same as if there were a new virus, a new bacteria, a form of disease that can affect children by passing from one carrier to another. "As parents, we would never hesitate to say it is our responsibility — not just our right, but our responsibility — to learn about that infectious agent and prevent it."

In the same way, "we should not naively and ignorantly let them catch drug abuse. And that's something we can carry to other different countries, whatever the drug, whatever the problem.

"Children today are the first generation in world history to have a massive and sophisticated marketing/merchandising education process going on that often contradicts the values of their parents, their churches, their temples, their synagogues, their governments, and schools.

"We're naive because it didn't happen to us as children. We didn't grow up that way, and it's something we have to learn how to deal with as adults."

She said teenagers should be applauded for surviving as well as they do in the often "very cheap and shoddy world we've let grow up all around them.

"Our commitment should be: 'It shouldn't have to be so hard.' We should make their environments a better place so they don't have to work so hard to stay alcohol and drug free."

Dr Schuchard, volunteer research director of PRIDE, is an English and history scholar. As Keith Schuchard, she wrote *Parents, Peers and Pot* and *Parents, Peers and Pot II: Parents in Action.*

'Drugs are a health issue — not politics, not religion'

(from page 1)

and young people from across the US, parents and/or government representatives from 51 other countries, and many of the leading US policy-makers.

US parents now reach straight into the White House for, and get, support.

Nancy Reagan, wife of US President Ronald Reagan, credits her first visit to a PRIDE meeting, three years ago, as the time when her "thinking on drug abuse began to crystallize. That visit genuinely marked a turning point for me."

Now the highly-visible, frequently-tearful spokesman for US parents is going international.

To this year's meeting, she came with the spouses of 15 other national leaders, including Canada's, hoping they might begin to feel as she did three years ago. Days later, she carried the message of the parent movement to Pope John Paul II at the Vatican.

It's a hard act for other countries, or parents, to follow. And the US movement has a decidedly "made in America" feel about it — one that doesn't translate comfortably beyond US borders, however close.

The meeting this year, for example, came complete with marching bands, cheerleaders, kids sporting 'America's Pride' tee-shirts, and all the fervor of a religious revival meeting.

To challenges that the movement is too conservative, too political, too religious, too fervent, leaders respond that the group represents a broad spectrum of opinion and that, in any event, people in the US do tend to be conservative, and essentially religious.

Dr Gleaton told **The Journal**: "This issue is not a religious, political, or moral issue. It's a health issue. We want support from everyone. We're not prejudiced.

"What we encourage other countries not to do is to become a political organization. We tell them 'Have tunnel vision. Focus on the child and the child's health. Use the instinct of the mother to protect the young.' "

Will the movement "take" in other countries?

The approach may not, but the idea may well, agree some of the foreign participants, who held several of their own small "international" meetings.

Cdn parents beware?

ATLANTA — More Canadian kids are probably using drugs than parents would believe, suggests Marsha Manatt Schuchard, PhD.

"When it becomes a casual, mainstream, accepted kind of thing, then all the nice kids get in. They don't have to make any kinds of choices. It's a normal act.

"That's what happened here up until 1979, when the effort to 'de-normalize' the usage began."

Next month in The Journal, **Elda Hauschildt reports from the PRIDE CANADA meeting in Saskatoon.**

US is not alone: Reagan

ATLANTA — Kids not policies; parents not politicians.

That's what Nancy Reagan is interested in, says Jon Thomas, United States assistant secretary of state for international narcotics matters.

And that's why the wife of the US president spearheaded the recent 'First Ladies Conference on Drug Abuse' in Washington.

"The challenge is how to get parents involved in other countries," Mr Thomas, also an adviser to Mrs Reagan on her conference, told **The Journal**.

"We don't expect other countries to drop everything and go after drug abuse," he said. "But there is the element of consciousness-raising, and I think the 'first ladies' who are here will go back to their own countries with more information, and perhaps be more interested, than when they came," he said.

The spouses of 17 government leaders accepted her invitation and, after a day of briefings on drug abuse issues in Washington, Mrs Reagan and 15 of them joined the PRIDE meeting for a few emotion- and information-laden hours. (Mrs Maria Lorenza Barreneche de Alfonsin, of Argentina, and Mrs Joan Fitzgerald, of Ireland, were unable to make the trip to Atlanta.)

"I wanted the first ladies to see what I saw on my first trip here, because conferences like this are possible in their homelands too," said Mrs Reagan.

"We in the US sometimes think that when we've got a problem, we're the only ones who have it. This conference is a means of letting parents in the United States, as well as around the world, know that they are not alone."

The 17 women who attended the mini-conference, all of them accompanied by officials of their own countries, were: Maria Lorenza Barreneche de Alfonsin, Argentina; Teresa Ormachea de Siles, Bolivia; Mila Mulroney, Canada; Rosa Helena Alvarez de Betancur, Colombia; Eugenia Cordoveze de Febres-Cordero, Ecuador; Marianne von Weizsaecker, Federal Republic of Germany; Joan Fitzgerald, Ireland; Anna Maria Craxi, Italy; Marie Elizabeth Seaga, Jamaica; Tsutako Nakasone, Japan; Siti Hasmah, Malaysia; Sarojini Devi Jugnauth, Mauritius; Paloma Cordero de la Madrid, Mexico; Anne Marie Willoch, Norway; Shafiq Zia-ul-Hag, Pakistan; Maria Consuelo Rivera de Ardito Barletta, Panama; Maria Manuela Eanes, Portugal; Nancy Reagan, US.

Canada

Jamaica

Japan

Italy

Portugal

West Germany

Pakistan

Ireland

NEWS

RESEARCH UPDATE

Prevention of alcohol withdrawal seizures

Oral diazepam loading can prevent alcohol withdrawal symptoms in patients at high risk for such seizures. That is the conclusion of two researchers from the Clinical Institute of the Addiction Research Foundation and the department of medicine of the University of Toronto. Dr Paul Devenyi and Marion Harrison selected a group of 20 patients with a history of alcohol withdrawal symptoms who were admitted to the medical ward of the Institute between July 1983 and April 1984. On admission, if the patients had no alcohol in their blood, or when withdrawal symptoms appeared if the patients were still intoxicated, patients were given a loading dose of 60 milligrams of diazepam followed by other doses as needed to control withdrawal symptoms, up to a total of 240 mg. None of the treated patients had a seizure during his hospital stay. The researchers said this method of seizure prophylaxis is effective with patients who do not have a history of seizures associated with factors other than alcohol withdrawal. They noted that at least one third of untreated patients who have had withdrawal seizures will have them again if they undergo withdrawal and also stated that phenytoin, the agent often used to control such seizures, has side effects that diazepam does not.

Canadian Medical Association Journal, April 1, 1985, v.132:798-800

Correction fluid inhalation deaths

Typewriter correction fluid has unique toxic properties which makes it a particularly dangerous agent of substance abuse with children, a study by three New Mexico researchers has found. The study evaluated four cases of sudden death in adolescents, directly related to the inhalation of typewriter correction fluid (TCF) during the period from 1979 to mid-1984, and identified by the New Mexico state office of the medical investigator. Investigation of the circumstances surrounding the incidents suggested the mechanism of death was a sudden cardiac arrhythmia associated with the solvents 1,1,1-trichloroethane and trichloroethylene found in the TCF. While manufacturers of TCF are beginning to recognize the potential for abuse of their products (**The Journal**, Feb 1984) the researchers said the fluid is still "a readily available and inexpensive agent now being used by teenagers to obtain a rapid 'high' by inhalation." They note that TCF appears to be gaining popularity within the school-aged population and is particularly toxic because in the period under investigation no sudden deaths resulted from the inhalation abuse of spray paint or gasoline which is also known to be widespread in the state. They also said that the danger of the TCF solvents only exists if they are concentrated and that "the small quantities of solvents released during normal TCF use should present no hazard to the user."

Journal of the American Medical Association, March 15, 1985, v.253:1604-1606

Sudden death in solvent abusers

A potentially important cause of sudden death in solvent abusers has been identified by researchers at a British hospital. The importance of respiratory depression separate from cardiac arrhythmias has been postulated by members of the medical unit of Westminster Hospital, London, following a case of reversible respiratory arrest after acute inhalation of an adhesive containing toluene. The 21-year-old patient suffered two respiratory arrests following a six-hour, glue-sniffing session, and had a six-year history of heavy solvent abuse. Admitted to hospital because of a severe behavioral disturbance, the patient had the arrests despite having a normal electrocardiogram. While most of the 80 annual deaths due to solvent abuse occur outside hospital, the three researchers said most of the sudden deaths are thought to be caused by cardiac sensitization leading to ventricular fibrillation. But, they said respiratory depression alone might be an important cause of sudden death with solvent abusers, and this is rarely picked up on autopsy because of the lack of distinctive features of this mode of death. They said respiratory depression might be expected in solvent abusers because animal studies have shown depression of the central nervous system function by solvents. The study suggests that patients who lose consciousness during or following solvent abuse be closely monitored.

British Medical Journal, March 23, 1985, v.290:897-898

Maternal drinking and fetal clubfoot

Finnish researchers appear to have uncovered a relationship between maternal drinking and fetal clubfoot. Three doctors reported that in an out-patient clinic for pregnant problem drinkers at University Central Hospital, Helsinki, 43 women had given birth between 1983 and 1984 after being followed from the 16th week of pregnancy to term. Of these women, three gave birth to clubfooted infants. Each of the women reported drinking heavily to the 20th week of pregnancy, and two consumed up to 70 grams of alcohol daily throughout the pregnancy. Two of the women were also cigarette smokers, although all three reported using no other drugs or stimulants. Apart from the clubfeet, none of the typical signs of fetal alcohol syndrome was seen in the infants, although one died of unspecified asphyxia during the 32nd week of pregnancy. The physicians noted that the frequency of clubfoot in this series was significantly higher than that seen in the general population, where 70% of newborns are evaluated by the Finnish Register of Congenital Malformations. As the only common factor in the three cases was extreme maternal alcohol consumption, the study concluded it may have caused the clubfeet.

New England Journal of Medicine, March 21, 1985, v.312.790

Pat Rich

Universities take first steps to campus alcohol program

By Pat Davies

TORONTO — In September, first-year students at two Ontario universities will be exposed to a program to help them moderate their drinking.

And, at least seven more universities are "giving serious consideration to full implementation" of the project, called CAPE (Campus Alcohol Policies and Education), John McCready, PhD, director of the Western Ontario region for the Addiction Research Foundation (ARF) told **The Journal**.

CAPE ran last year at the University of Western Ontario (UWO) in London and will be repeated there again. McMaster University in Hamilton will also implement CAPE, which includes booklets, posters, buttons, exhibits, and ads in campus newspapers, all stressing the need to drink moderately (**The Journal**, January).

The program costs about two dollars per first-year student, David Hart, ARF community consultant, told a recent symposium on CAPE. Last year, UWO contributed $6,000 toward the program for its 4,000 first-year students.

Tom Siess, PhD, UWO's director of student services, says that in the program's first year, UWO administrators found trying to change student drinking habits "frustrating, at times aggravating, and painstaking."

He warned other university administrators they would have to exercise patience, as it is going to take several years to change entrenched practices. He added, however, that "all of us who have been party to (the project) have been impressed with the high degree of willingness to change" among the students.

He cited two particular stumbling blocks: students' aversion to apparently paternal administration practices, and concern about reducing profits generated by campus pubs.

While CAPE's awareness promotion has gone smoothly, the policy part of the campaign, concentrating on the serving, availability, and pricing of alcohol on campus, "has grown considerably more slowly," he said.

UWO originally agreed to implement CAPE because of concern about the rising number of licenced events on campus, and what would happen if the university were sued for an accident following campus pub drinking. "I have an interest in covering my own backside," Dr Siess put it. He added students certainly recognize liability concerns as real problems.

John La Roque, ARF director of regional programs, told the 100 university administrators at the meeting that ARF was prepared to supply staff to plan and implement the program at each university and would consider making a financial contribution.

McCready: consideration

Students okay cut-back on drink

TORONTO — Advertisements in student newspapers are an effective way to reach students with a message to moderate their drinking, suggests a survey by Louis Gliksman PhD, a scientist with the Addiction Research Foundation (ARF).

He is evaluating a year-long program called Campus Alcohol Policies and Education (CAPE) at the University of Western Ontario, and delivered some preliminary results to a recent CAPE symposium.

Dr Gliksman completed a survey on CAPE's impact on second-, third- and fourth-year students. Among the 560 students randomly surveyed, 56% had seen ads in the campus newspaper and 68% had a general awareness of the program. (Virtually every student surveyed endorsed the idea of a campaign to help students control their drinking.)

Fifty-six percent said they had noticed light beer was cheaper than regular beer in campus pubs, another part of CAPE. Of those who had noticed the change, an overwhelming majority thought it appropriate to charge less for low-alcohol beer and 26% said the price influenced what beer they chose.

Evaluation of CAPE's impact on first-year students, the target group, is now being done, along with testing at a comparison university. Beverage sales at campus pubs are being surveyed to see if CAPE has led to change in drinking habits.

Alcohol's often a backdrop

Family ills can spawn later suicide

By Betty Lou Lee

TORONTO — Suicidal women who grow up in chaotic families tend to cope through one of two extremes: rebellion or over-conformity. When those in the latter group try to take their lives as adults, they make more attempts and use more violent methods, such as guns and knives.

Joyce Stephens, associate professor of sociology, State University of New York at Fredonia, calls them "cheap thrill" girls and "humble pies." Dr Stephens has been studying 50 adult women who have attempted suicide a total of 84 times.

Most of them come from severely disorganized homes with high rates of alcoholism, mental illness, beatings, sexual abuse, and parental separation.

"As teens, they were severely depressed, and chose one of two methods of adaptation or coping," Dr Stephens said in an interview at the 18th annual meeting of the American Association of Suicidology.

"The 'cheap thrills' were rebellious, defiant, acting out — taking drugs and sexually active.

"The 'humble pies' were almost like martyrs, always trying to please and appease. They took on a burden of responsibility, but also a burden of guilt. They told themselves if they were good enough, they could make it all right.

"Both strategies fail, but the humble one may be more hazardous in the long run. When they try suicide later on, they make more multiple tries, and with more violence, like a butcher knife in the stomach."

Dr Stephens said she is not claiming that a particular kind of adolescence "causes" later suicidal behavior, but is trying to find common patterns. She found adolescence instrumental in developing feelings of worthlessness, rage, and hopelessness.

The 'humble pies' are more likely to be middle-class, and many of them are well-educated and attractive, but they feel they are failures. Several spoke of mothers who demanded that they be perfect, but were never satisfied with any achievements.

Their relationships with men "are a mess. Either they have an unerring ability to pick disastrous mates," or men can't abide their smothering type of love and excessive needs. One quarter of them are in battering relationships.

One 'humble pie,' with an alcoholic father, told Dr Stephens, "I feel like I'm bad. Not bad morally, but just totally incapable of doing anything right. I really worked hard to satisfy him, but no matter what I did, it really wasn't good. I failed my father all the way along the line . . . . My mother went through a lot with him; she's a stoic and suffers everything in private and apparently has the strength to do it. She survived; well, I didn't, and I haven't, so I felt and feel that I failed."

Another, whose parents were alcoholics and the father suicidal, told of pulling her hair out and shaving her eyebrows off.

"There was something that made me want to hurt myself because I was guilty . . . . Those bad feelings wouldn't go away. I was attracted to knives and razors."

Another said, "I loved my father, but he drank and beat my mother and would bust up the house . . . . Basically, I just stayed in my room and I reached the point where I didn't want to be alive."

One of the women in the study, aged 37 years, and with two college degrees, recently killed herself on her third try. Dr Stephens expects another five of them will succeed at suicide within 10 years.

NEXT MONTH
The United States National Invitational Policy Forum

NEWS AND COMMENT

Co-alcohol families need help

WINNIPEG — Successful treatment of alcoholics must also include treatment of families, says a United States addictions counsellor.

Terrence Gorski said families of alcoholics suffer from 'co-alcoholism,' a condition in which people behave abnormally, because of the stress they encounter in living with an alcoholic.

"They need treatment for themselves," said Mr Gorski, president of Alcohol Systems Associates, a private firm specializing in consultation and training in the addictions field.

"They often create a system that says, 'As soon as he gets well, I'll get well.' But that doesn't necessarily follow. If a family unit remains dysfunctional, the stress level can promote a relapse (by the alcoholic)."

Mr Gorski, in Winnipeg to give a two-day workshop for addictions counsellors at the Alcoholism Foundation of Manitoba, suggested an alcoholic has not recovered just because he stays sober. Often, he said, alcoholics suffer from the "dry-drunk syndrome" or "white-knuckle sobriety" when they stop drinking. Although they are sober, they still suffer from mood swings, memory losses, and other problems because of the brain damage caused by alcohol or other addictive substances.

Such brain damage, known as post-acute withdrawal, may not correct itself for up to 24 months, Mr Gorski said. For successful recovery, alcohol and addictions counsellors must not only ensure that clients stop drinking, but that they don't substitute their need with other drugs or compulsive behavior.

He said the alcoholic who wakes up sober in the morning but then must down five cups of coffee and smoke five cigarettes before starting the day, has relapsed. Nicotine and caffeine are stimulant drugs, but few counsellors recognize this because both products are socially acceptable, he told **The Journal**.

"I think we are going to have to come to the point where we ask: Are these drugs? Are these really addictive?"

He said many times alcoholics, and others who are chemically dependent, take up some other form of compulsive behavior to fill the void left by alcohol and other drugs. The only effective recovery for addicts comes when their biological and social relationships can be changed without dependence on chemicals, or other forms of compulsive behavior.

Province wants safe grads

FREDERICTON — The New Brunswick Alcohol and Drug Dependency Commission (ADDC) is placing emphasis on programs aimed at safe graduations from the province's high schools.

During 1984, a spring Safe Grad planning conference garnered representation from 22 English and 19 French high schools, while two November conferences attracted representatives from 27 English and 18 French institutions. The latter gatherings initiated planning for 1985 graduations.

Special programs are being drafted in Fredericton, Oromocto, St John, St Stephen, Harvey, and Grand Manan and more schools will soon become active in the program.

GILBERT

'Eradicating khat seems hardly the proper solution unless, as in Saudi Arabia, there are resources to eradicate poverty as well.'

Khat: use and abuse

Second of two parts

By Richard Gilbert

This is the second of two columns on khat, described in a recent World Health Organization (WHO) report as "an amphetamine-like plant material." In April, I outlined the chemistry and pharmacology of khat. Its main active ingredient, cathinone, is very similar in structure and effect to *d*-amphetamine, although with slightly less potency. Here I shall describe briefly how and where khat is used, and what is being done about its use.

Khat is in the news this year because of a report in the January 20 edition of the London *Sunday Times* with the headline "Arab danger drug on sale legally in Britain." A reporter was able to buy a 200-gram bundle of khat for £5 (about $8 in Canadian funds). A user chews such a bundle of tender leaves and stalks over a period of five hours, experiencing banishment of fatigue, mental alertness, and relaxation, and other effects described in the previous article.

Khat, noted the *Sunday Times* report, is being imported into Britain by the hundreds of kilograms, mainly for sale to immigrants from North Yemen and nearby countries. Because khat loses its freshness and effectiveness in a matter of days, even with careful storage, international traffic on this scale is possible only where, as in London, there is a ready market and distribution network.

Major business

International trade in khat in east and north-east Africa and the Arabian peninsula is measured in tonnes. Djibouti, the small country on the south-west side of the southern entrance to the Red Sea, is said to import eight tonnes of khat daily by air from neighboring Ethiopia — 80 grams for each of Djibouti's 100,000 adult males. The distribution and sale of this imported khat seems to be Djibouti's major business: about 8% of the workforce is involved, in a country where the unemployment rate is said to be as high as 80%.

Another major importer is Somalia, the country east of Djibouti, which, like Djibouti, has neither soil nor climate suitable for khat production. Unlike Djibouti, where khat use has been a part of the culture for centuries, widespread use of khat by Somalis appears to have developed during the past four decades, to the extent that in 1981 it was generally estimated that 75% of the men and 7%-10% of the women chewed khat regularly.

Across the Strait of Bab el Mandeb from Djibouti, on the Arabian peninsula, are North and South Yemen, where khat is grown extensively, and where use of the drug is nearly universal. A 1972 WHO mission to the Yemen estimated that "approximately 80% of adult men in the major cities and 90% of adult men in the villages of regions in which khat is produced are regular khat chewers. The prevalence of khat chewing is lower among women and in rural areas where khat is not produced."

Khat chewing is a central feature of existence in these four countries and, to a lesser extent, in other countries of the region, including Ethiopia, Kenya, and Madagascar. Most chewing occurs at khat parties, which take place for hours each afternoon. A recent WHO report notes that the khat party "is conducted in an elaborate and well-developed social setting. Under the stimulating effects of khat, the group dynamics and social interaction are enhanced. The mood is high and a general sense of well-being prevails."

A ritual

Peter Keehn, a York University psychology professor, interviewed the eminent Arab scholar Yusef Ibish in Beirut a few years back. Here are some of Ibish's comments about khat and khat parties:

> ". . . The first time I went to Yemen I was full of prejudice against khat.
> • . . . To my utter surprise, the gathering was of the highest academic calibre and they were discussing very formally some legal problems and precedents in the Koran. I was very impressed by the level of academic standards, as well as by the civilized manner in which they were carrying on the chewing of khat.
> • . . . The session took from roughly 2 pm till about 6 or 7 pm, but the continuous chewing had no ill-effect on these people. The only thing I was astonished at was the amount of water they drank.
> • . . . I tried the khat. I chewed, inexperienced as I was. And that form of khat takes a bit of experience to chew. I kept up with them and chewed as much as any person in the room and again I was impressed by how marvelous the conversation was, how civilized it was.
> • . . . Later I experienced a little insomnia.
> • . . . Another side-effect, which I was told later was normal, was constipation, which was eased by a laxative and left no ill-effect.
> • . . . Gradually I came to realize that it was not what I had been told it was. The circle was highly civilized, nothing like the Western cocktail party, or the depressing hashish parties elsewhere where people feel full or dopey and do not communicate.
> • . . . It's quite a ritual, like English high tea, which is drunk at a certain hour.
> • . . . In a society that has a lot of oral tradition to pass from generation to generation, the khat party is an educational kind of circle, where transmission of information, from person to person, from generation to generation, takes place,"

According to Dr Keehn, attitudes in North Yemen toward khat range from "an addiction responsible for the health and economic problems of the country to a harmless social custom in a culture bereft of other forms of entertainment."

Restructured economy

Some of the governments in the region have taken the view that khat use is a socio-economic problem. Egypt, Sudan, and Saudi Arabia have all forbidden cultivation of and trade in khat. Saudi Arabia has been particularly diligent, partly for religious reasons and partly because of khat's impact on the economy as a distracter and debilitater of the work force. Users can be flogged, and dealers in khat can be jailed for 15 years.

The Saudi Arabian government has also acted to restructure the economy of the Gizan region, where most khat is used, through the establishment of a special Board of Development. These attempts have focused on destroying khat plants and replacing them with other marketable crops, chiefly coffee and bananas. According to the Board's Director-General, methods have included "Employing people in the Board and other governmental services and companies in the region to guarantee a stable salary keeping their mind away from khat."

Governments in Ethiopia, Kenya, and Somalia have also tried to restrict khat cultivation, trade, and use. These attempts have mostly failed in the face of stiff resistance from users and, particularly, producers. Bureaucrats also resist controls on khat, fearing the short-term disruption that restrictions might cause to a fragile economy. Ethiopia's main cash crop is coffee: it is the world's sixth largest producer. But one report suggests that income from khat may be 10 times greater than that from coffee.

In Djibouti and the two Yemens, action against khat appears limited to education about its harm, and to probably unheeded advice to farmers to grow other crops.

Vicious cycle

The four countries with the greatest khat problem are four of the poorest countries in the world. Whether poverty, rapid urbanization, and mass unemployment contribute to khat use, or vice versa, is not clear to this distant observer. At an international conference on khat in Madagascar in 1983, Dr A.D. Krikorian of the State University of New York at Stony Brook, and Mr A. Getahun, a Kenyan participant, argued as follows:

> • ". . . Khat chewing is good for the poor, according to the chewer, as it provides one with a dream-world or fantasy. After chewing, the poor man imagines that he has everything and possesses the world. Khat chewing for the rich, on the other hand, appears to provide worry wherein one may think he has suddenly lost his wealth or business.
> • . . . Health-wise, the consequence of khat chewing is not as severe on the rich as it is on the poor.
> • . . . The urban poor is the group that is most affected socio-economically as the habit depletes income and health as well as reducing economic productivity.
> • . . . The general trend is for individuals to reduce their dependence on khat as they move up in the economic and social ladder. The reverse is true, however, among the poor. The poorer one gets, which is fueled by one being a khat habitué, the more khat-dependent one becomes."

The Madagascar conference called for research, education, and community development, and for affected countries to examine the possibility of concluding agreements to restrict trade in khat.

Madagascar's Minister of the Interior, who opened and closed the conference, noted that "khat remains a plant open to question. It is a 'secular' plant, if one can use that term: it has been making its appearance for several centuries, and it is anchored in the traditions of many countries . . . . To pull out or uproot a secular plant or tree, a lot of strength, a lot of patience, and a lot of resources are necessary."

Most drug abuse, in my view, consists of excessive use of substances that, used in moderation, may be no more than adjuncts to desirable social behavior. Khat, by its nature, is difficult to use to excess. A lot of effort is required to ingest even a moderate dose of cathinone, the main active ingredient. Profound changes in the countries around the Strait of Bab el Mandeb have created large pockets of urban poverty whose victims have plenty of opportunity to work at extracting large daily doses of cathinone from readily available supplies of khat. Eradicating khat seems hardly the proper solution unless, as in Saudi Arabia, there are the resources to eradicate poverty as well.

Unlike the crops that give rise to heroin and cocaine, there is little that developed countries have to fear from khat. The London market will likely remain an isolated example of export of khat from the region of production. Our concern about khat should be part of our broader concern for urban distress in The Third World.

NATIVE CANADIANS

High birth-rate will boost alcoholism in Saskatchewan Indians

By Peter Edwards

REGINA — More than one in three of the Saskatchewan adult Indian population has an alcohol problem and there's a grave danger of the problem getting worse, says a new report.

The report by the Federation of Saskatchewan Indian Nations (FSIN), blames 70% unemployment among provincial Indian adults for much of the problem. It says 49.1% of unemployed Indians in the province abuse alcohol compared with 24.3% for Natives with jobs.

Cultural understanding is essential in dealing with the problem, said Zach Douglas, who worked on the report as a consultant for WMC Research Associates (Sask) Ltd. "Part of the answer is to make sure the alcohol and drug abuse program that is developed is culturally-based," Mr Douglas said. "It helps individuals to re-establish contact with their cultural roots and norms.

"Only an Indian-controlled institution can really deliver that kind of culturally-based programming," Mr Douglas said.

The report indicates alcohol abuse levels are between 35% and 40% for Saskatchewan adult Indians, with drug abuse levels between 20% and 25%. Alcohol abuse among 15-to-19-year-old Saskatchewan Indians is between 10% and 15%, with other drug abuse affecting between 5% and 10%.

Chronic alcohol and other drug abusers make up 15% of the adult group and 3% of adolescents.

There's a danger of a dramatic inerease in alcohol abuse as the Indian population rises at a rate of 2.6% a year, compared to 1% for Saskatchewan's general population, the report says. Forty-eight percent of Saskatchewan Indians are younger than age 19, and many of them will move into the alcohol "at-risk" age group in the next five years.

Alcohol problems tend to get progressively worse, the report says.

"There is a marked increase in alcohol abuse levels as age inereases from 15 through to 59, when abuse levels begin to decline," it states. "Adolescent abuse levels are approximately one-third of those in the adult population."

Mr Douglas said there isn't much information on alcoholism levels for the overall Saskatchewan population.

"From what general information I was able to obtain, I'd have to say the levels are not that different," Mr Douglas said.

The report gives a grisly list of social problems connected with alcohol abuse, pointing out the life expectancy for a Saskatchewan Indian is 10 years less than for a non-Native. The provincial Indian suicide rate is more than four times that of the general population, making up 13% of all Indian deaths in 1982.

One in eight Indian men in Saskatchewan are likely to be jailed in a year, the report states, and infant mortality is double that of the general population.

"It is not surprising, that in this kind of social and economic environment, alcohol and drug abuse are widespread," the report says.

"Abuse of alcohol or drugs can not be viewed in isolation from the community or group in which it occurs," the reports says. "Abuse is interwoven with the social and economic fabric of the community. It is not an isolated problem experienced by a few individuals who can be removed from the community, treated, and returned to it."

The supply of beds for in-patient treatment is less than a quarter of what's needed, according to the report. There are 24 in-patient treatment beds in Saskatchewan, while 102 are required. Fifty-two beds will be in service by the end of the 1985-86 fiscal year, if two planned projects are completed, said Mel Isnana, chairman of the FSIN Health and Social Development Commission.

Mr Isnana said treatment beds cost about $66,000 each, which is double what the federal government estimated in 1984. That means the FSIN needs an additional $3.5-million for beds, he said.

Isnana: desperate needs

Mr Douglas said the FSIN has made in-roads into accessing needs and delivering services, and said Indian-controlled and administered programs are essential.

"There are Indian AA (Alcoholics Anonymous) groups," he said. "They're perhaps one of the more effective intervening agencies at this time. But they can only go so far, because they can't really deal with the cultural issues and economic and social conditions.

Mr Isnana said the report is the starting point for a comprehensive program to address alcohol and other drug abuse. It was drawn from interviews with 898 adults on 12 reserves and five urban areas, and 385 Indian adolescents 15 to 19 years old between February and July 1984. All interviewing was done by Natives.

Mr Isnana said 40% of Saskatchewan reserves desperately need alcohol counselling programs and greater training is needed for workers at reserves with programs. Officials of the FSIN plan to follow-up their first-ever provincial addictions conference with workshops to increase community involvement in treatment programs, Mr Isnana said.

The report was presented at a FSIN conference on alcohol and other drug abuse entitled, A Focus on Culture and Lifestyle.

Steve McArthur, director of the FSIN Health and Social Development Commission, said community work must involve a spiritual component from either mainstream or traditional religious.

"A lot of our people haven't got that faith," Mr McArthur said. "Somehow, the candle has gone out."

Native workers battle alcohol, suicide

REGINA — Laughter is a useful tool in fighting alcohol and other drug abuse, says Bea Shawanda, director of the Magwa Gani Gamig (Rainbow Lodge) community centre for Natives on Manitoulin Island, Ontario.

"We really believe that it (laughter) has a healing value," Ms Shawanda, told an alcohol and drug abuse seminar held by the Federation of Saskatchewan Indian Nations (FSIN), Health and Social Welfare Commission. "It's a resource that we have available. We have to learn to use it."

Used correctly, laughter and play therapy can break down a sense of isolation common to suicidal people, Ms Shawanda said. "The need to laugh must be satisfied in order to grow. It is a known fact that laughter produces physiological changes in fighting disease. The cardiovascular-respiratory systems are all affected."

It was Ms Shawanda's skill in preventing suicides that brought her in contact with Mel Isnana, chairman of the FSIN Social Development Commission, two years ago. (See related story.) Mr Isnana was then chief of the Standing Buffalo band, which had four suicides that summer. The band has had one suicide since Ms Shawanda's two-week visit.

"One of the things she stressed was that a communication gap is part of the problem," Mr Isnana said. "We feel that the technique Bea is teaching, and her philosophy is helping get things back together in the Native community."

A grim cataloguing of Indian suicide in the province was presented by Sidney Fiddler of the FSIN. The Saskatchewan Indian suicide rate is 4.3 times the national average, Mr Fiddler said. He added there's a self-destructive element to many other violent deaths, including car accidents, fires, and poisonings.

Mr Fiddler said the suicide rate for Saskatchewan Indians less than 14 years is 27.5 times the national rate, and 41 times the national figure for girls less than age 14. It's 11.5 times the national suicide rate for the 15-to-24 years age group and 3.6 times the national rate for 25 to 44 year olds.

Mr Fiddler estimated figures are roughly comparable for Saskatchewan's Metis and non-status Indians.

"There's no program right now that deals with it," said Mr Fiddler, who called for Native-controlled programs with a strong Native cultural emphasis.

Alcoholism among Natives is a by-product of a "systematic de-socialization" of Indian people, he said, and would be lessened with increased job opportunities, more political control, and community-level action.

"It's a matter of convincing white politicians that's what's needed," Mr Fiddler said. "They're the ones with the bucks . . . (but) with the fiscal restraint, it's not a priority for governments."

Mr Fiddler and Ms Shawanda said adolescence is tough for anyone, but doubly tough for an Indian. "Our young people are trying to live with one foot in one culture and one in the other culture," Ms Shawanda said. "Who's there to guide them?"

Fiddler

Shawanda

She said her experience at a boarding school run by priests and nuns left her bitter at white society, but she has moved beyond those feelings. "We've talked ourselves to death with causes and effects," she said. "We need to act."

Ms Shawanda, an exuberant 40-year-old grandmother, said it's not fair for parents to pass anger down to their children. She argued it's possible to remain Indian while choosing things from white culture.

Ms Shawanda said it hasn't been tough to get people on the brink of suicide to join in laughter and play therapy, which can involve dancing back-to-back with a stranger or imitating a barnyard animal. The laughter casts problems in a different, less severe light, she said.

"Native people have a tremendous capacity for looking at tragic situations and seeing something funny there," she said. "Maybe that's why we have survived."

Howell's guide to intoxicating description

By Wayne Howell

Paul Dickson, author of *Words — A Connoisseur's Collection of Old and New, Weird and Wonderful, Useful and Outlandish Words*, modestly claims that his compilation of 2,231 words or expressions that describe a state of intoxication with alcohol is a world's record.

He has taken words from Benjamin Franklin's seminal 1733 opus, *Drinker's Dictionary*, added words from assorted dictionaries, such as *The American Thesaurus of Slang* and *Dictionary of American Slang*, and drawn on a wide variety of additional sources. Two thousand, two hundred and thirty-one words and expressions relating to inebriation make a pretty impressive list, all the more so when you consider there are only 80 entries under the heading Sexy Words in Dickson's book.

I once knew an anthropology student who, when faced with any kind of data, always said, 'I'd like to do a study on that." She saw the world as a sort of continual master's thesis.

I lack that kind of academic enthusiasm. Nevertheless, there was something about Dickson's mountain of words that made me want to go for a climb. I was curious, for instance, about the ratio of Pleasure Expressions, such as "blissed out," to Pain Expressions, such as "barleysick." It seemed to me that this list of expressions might tell us something about grass-roots perceptions of drinking behavior and its consequences.

And so, I set out to 'do the study' myself. I quickly discovered that it was going to be a rather subjective affair. "Floating high" is obviously pleasurable, just as being "floored" is obviously painful, but how do you categorize "flummoxed," or "foozlified?" I was about to abandon the project when an interesting thought hit me: the person who opens up a new school of academic endeavor can just wing it. It will be 10 years or more before scholars who follow in my footsteps will have the temerity to challenge the famous Howell Classification System, which goes as follows:

Type A Expressions: these are words or expressions suggesting happiness, euphoria, and transcendence. Example: "in a rosy glow."

Type B Expressions: these suggest stupefaction and/or mental disorganization. Example: "in a fuddle."

Type C Expressions: these suggest hyperactive or violent behavior. Example: "Ramping Mad."

Type D Expressions: These make direct or indirect references to disease or death. Example: "mortally drunk."

Type E Expressions: Words or expressions that won't fit into, and cannot be squeezed into, categories A to D. Examples: "Muckibus," "catsood," and "done an Archie."

There were 460 Type A expressions (20.6%). There were 1,074 Type B expressions (48.1%). There were — surprisingly — only nine Type C expressions (0.4%). There were 283 Type D expressions (12.6%). And, there were 415 (a healthy 18.6%) Type E expressions left over to be categorized by future scholars in the field. If we put those aside for the moment, then the study shows that out of 1,826 common or bar-room references to intoxication, 25% of them associate drinking with pleasure and euphoria, and 75% associate drinking with stupefaction, disorientation, disease, and death.

But, is there a certain 'gallows' or 'existential' humor operating here? Are stupefaction, disorientation, disease, and death really sublimations of desirable mental states? Or are they, given the state of the world — economic insecurity, the threat of nuclear holocaust, etc — perceived as desirable mental states by some people? These questions I leave to future scholars with government grants and research assistants.

INTERNATIONAL

Greeks evaluate data on first drug use survey

By Emmanuel Hadzipetros

TORONTO — Responding to "signs" that a drug problem may be developing in Greece, researchers at the University of Athens department of psychiatry have recently completed the Mediterranean nation's first-ever drug use survey.

Dimitra Madianou, a social anthropologist involved in the study, told **The Journal**: "Until the 1960s, there was very little drug abuse in Greece. There was some hashish use, but the smokers were never a big problem, and there were virtually no heroin users."

The 1970s, however, brought indications of a worrying change.

"There were two signs that a problem may exist," Dr Madianou explained. "First, more people were being admitted to the out-patient departments of hospitals with drug problems. There was also an increase in the number of drug-related arrests."

Young Greeks: comparing what students said in and out of school

Whether these "signs" represented the tip of a drug iceberg or were simply isolated incidents, the strongly family-oriented public became concerned. Neighborhood parent committees were formed and, following Greek political tradition, noisy demonstrations were held.

The press responded with dramatic headlines and pictures, particularly when a death resulted from heroin overdose. (The response to the recent drug death of a promising young athlete was typical; many newspapers featured color photos of his corpse and the dishevelled room in which he had been found.) Political parties also got in on the act.

"Public concern was high," Dr Madianou said. "But, in spite of the emotional nature of the debate, nobody really knew if a drug problem even existed. The purpose of our project was to answer that central question: 'Do we have a problem?' If so, how extensive is it, and what segment of the population does it affect most? We wanted to know so that we could begin planning preventive measures."

A proposal for the survey was written by a team of scientists from the University of Athens department of psychiatry, under the direction of Professor Costas Stefanis, who is also president of the World Psychiatric Association. Funds were provided by the Greek Ministry of Youth, which gets high marks from researchers for its interest and support.

So does Lloyd Johnston, PhD, senior researcher for the annual University of Michigan nationwide survey of high school seniors, sponsored by the United States National Institute on Drug Abuse (**The Journal**, March). Dr Johnston visits the research team regularly and was instrumental in developing the project in Greece, said Dr Madianou.

The project involved two surveys which began in March, 1984 and ended in June that year. One was administered to a representative sample of 11,000 students — aged 14 to 18 years — in 100 lyceums (equivalent to the last three years of high school) throughout Greece.

Questionnaires were handed out during school hours. Students were given two hours to answer more than 200 'yes' or 'no' questions dealing with a range of subjects, including health, social attitudes, and religious beliefs.

"Questions about drugs were slipped in among the health questions, near the middle of the survey, so as not to be threatening to the students," Dr Madianou explained. "It was important for us to win the confidence of our subjects."

Madianou: personal histories

Another confidence-building measure was the exclusion of teachers from all aspects of the study. "We had written permission from the ministry allowing us to administer the survey in the classroom."

The other survey was of a random sample of 4,500 people from the general population, broken into three age groups: 1,200 students and non-students between 12 and 17 years old; another 1,200 between 18 and 24 years; and the remainder from 25 to 64 years.

"We realized that there would be some overlapping between the two studies," Dr Madianou said. "We wanted to compare what students would say in and out of school."

Dr Madianou was hesitant to talk about results. "It's too early," she pointed out. "We haven't published our report; we can't yet speculate on what drugs are the most abused, what age group is most at risk, or even if a problem exists. We are still evaluating the data.

"The next phase," Dr Madianou said, "is to begin long-term studies of the social and psychological context — to gather complete personal histories of drug addicts, and then follow their lives closely. We can do it; the data is there. Greece is a small, friendly country, and it's easy to do the research."

Dr Madianou was in Toronto to visit the Addiction Research Foundation.

Research to look at traditional hash smoking

TORONTO — Social anthropologist Dimitra Madianou is no newcomer to drug research. Through the 1970s she was involved in a field study of a community of traditional hashish smokers living in a slum area of Athens.

The project began in 1971 and received funding from the United States National Institute of Mental Health (NIMH), in Washington.

"My subjects were refugees from southern Asia Minor — modern Turkey — where hashish smoking was common," she said.

Two groups in the same neighborhood were monitored until 1978, when the project concluded: one smoked, the other didn't. The NIMH became interested because, aside from tobacco, hashish was the only drug the subjects used. "This gave us the opportunity to study the long-term effects of hashish use in a community where it was widely accepted.

"Hashish was integrated into the everyday lives of the Athens slum dwellers," Dr Madianou related. "Many smokers worked in the slaughter house, as cutters and skinners; hashish smoking came to be connected with the job. They were often introduced to the drug by a family member, and it was always smoked socially in groups."

Until 1954, hashish smoking was only a misdemeanor in Greece. Use of the drug became a serious offence that year, but it wasn't until 1960 that police began enforcing the new law: smokers suddenly found themselves criminals.

Further reductions in the ranks of smokers came as area residents upgraded their economic and social status.

"The link — if any — between present drug abuse and traditional hashish smoking is the next question to look into here," Dr Madianou said.

"In other words, does the fact that somebody comes from a family whose members smoked in the traditional way, have any bearing on whether he is more likely to fall into modern patterns of drug abuse?"

'Entire cities have outlawed smoking'

USSR using bans, education to battle tobacco

The following report was prepared for **The Journal** *by Jim Steeves of the USSR Embassy Press Office in Ottawa.*

A recent decision by Moscow officials to ban smoking in Red Square is one step in the Soviet Union's anti-smoking battle.

The campaign in recent years to end smoking as a social habit includes a ban on cigarette advertisements in any media in the country.

Also forbidden is smoking in most public places, including entertainment spots, health institutes, stores, restaurants, schools, all public transit vehicles, and in the workplace.

The USSR took these measures, the Embassy Press Office here says, because both Soviet and foreign studies clearly show the dangers posed by cigarette smoke.

Recent findings by Soviet scientists also show that cigarettes are a major source of heavy metal pollutants of the atmosphere. Heavy metals such as cadmium and lead are suspected of causing, or contributing to, ailments such as high blood pressure and cancer. The studies found that the quantity of heavy metal particles released into the air every year by the world's smokers is roughly equivalent to that released by one or two volcanic eruptions.

Soviet health officials realized that ending smoking is a monumental task, the Embassy says. Bans and large price increases have little or no effect on people's smoking habits. Historically, even the threat of excommunication has failed to deter people from lighting up.

In the USSR, cigarettes now cost 50 cents a pack — more expensive than in Canada in terms of income.

Thus the emphasis is now on a public education campaign designed to make people more aware of the health risks posed by smoking.

The battle is being carried to the schools, clubs, and factories where smoking has been banned and where experts visit to discuss smoking's harms and the economic costs of health care for smokers. Doctors and scientists also regularly discuss smoking on radio, television, and in booklets distributed free to the public.

"No smoking" signs and posters urging people to butt out are now a common sight in the USSR.

Most posters detail the various harms caused by smoking, while some have more tangible messages, such as "an average smoker spends about 5,000 roubles (Cdn $8,000) on cigarettes in a lifetime. Wouldn't it be better to spend the money on something else?"

Entire cities, such as the resort cities of Sochi and Yalta on the Black Sea, have outlawed smoking within city limits. On the main approaches to Sochi, city officials recently erected banners which say, "The resort city of Sochi welcomes non-smokers."

The public education drive is coordinated by a commission with representatives from the USSR's ministries of public health, culture, and education.

Studies have found that people are getting the message and that as many as 70% of people understand the health risks associated with smoking, the Embassy says.

However, there are still 400 billion cigarettes sold annually in the Soviet Union.

It is also recognized here that quitting smoking isn't as easy for some as it is for others. Several self-help and medical programs have been devised to help smokers butt out.

Some of the programs are as simple as organizing support groups. Other programs use more advanced techniques, such as hypnosis and auto-suggestion.

For some people, medical solutions prove to be the most effective. One of them is a new chewing gum developed at the Byelorussian Research Institute of Sanitation and Hygiene.

Tablets containing lobeline or cytisine medications used for stimulating respiration and cardiovascular activity are also used in the USSR as nicotine substitutes.

A similar technique uses a mouthwash or astringent spray applied to the mouth. The spray combines with cigarette smoke to produce a disagreeable taste, but the effect lasts only 10 to 20 minutes.

Cigarette pack warning: The USSR Ministry of Health warns that smoking is hazardous to health.

EDITOR
Anne MacLennan

PRODUCTION EDITOR
Terri Etherington

CONTRIBUTING EDITORS
Karin Maltby (Toronto)
Harvey McConnell (Washington)

CONSULTANTS
Dr Oriana Josseau Kalant
(Science)
Robert Solomon
(Law)

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street Toronto Ontario M5S 2S1
Editorial (416) 595-6053 Advertising 595-6113 Subscriptions 595-6056

CORRESPONDENTS

John Carroll (New Brunswick)
Maureen Brosnahan (Winnipeg)
John Dornberg (Munich)
Tom Land (London)
Betty Lou Lee (Hamilton)
Alan Massam (London)
Lachlan MacQuarrie (Hong Kong)
Jean McCann (Cleveland)
Pat McCarthy (New Zealand)
David Milne (Toledo)
Tim Padmore (Vancouver)
Lynn Payer (New York)

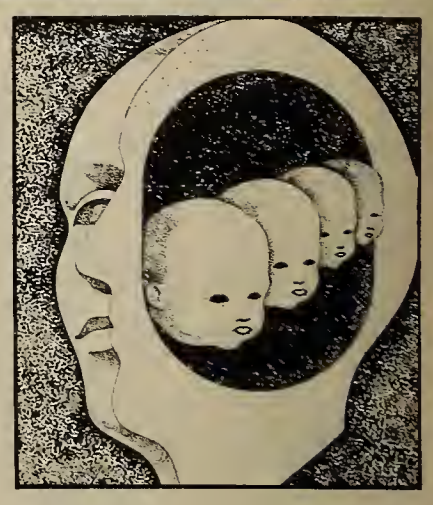
Member of cup

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

The Children Remembered—

Readers respond on familial alcoholism



Thank you for the article in **The Journal** about adult children of alcoholics. It aroused so many emotions that if I began to express them all, this letter would quickly become a novella.

Would you be kind enough to send me the mailing address for the United States National Association for Children of Alcoholics?

Thank you, and I would like to add that your informative paper is very much appreciated.

Susan Smither
Scarborough, Ont

* * *

As the adult child of an alcoholic parent, I am looking for any help I can find.

Please send me your bibliography from the synopsis of the presentation by Sharon Wegscheider-Cruse (**The Journal**, April), as well as the address of the United States National Association for Children of Alcoholics, if these are still available.

Thank you.

Chris McLean
Thunder Bay, Ont

* * *

We would appreciate, very much, receipt of a copy, if such is available, of your October 1984 piece, Families and Alcohol, a legacy of love and pain.

Also, we would like a bibliography and the mailing address for the United States National Association for Children of Alcoholics (**The Journal**, April).

Many thanks in anticipation.

Patrick J. Hunt
Michael Power High School
Islington, Ont

* * *

I have enjoyed your feature articles on the children of chemically dependent parents (**The Journal**, May, April, October 1984).

I am interested in researching this further and would appreciate receiving your bibliography with any related articles on the subject. I work in the field as an addiction counsellor.

Thank you in advance.

Jim Brodie
Toronto, Ont

* * *

I want to express my appreciation for the special section, The Children Remembered (**The Journal** May, April).

It was most interesting and informative.

Could you please supply me with the information on the United States National Association for Children of Alcoholics?

As a long-time subscriber, thanks for the consistent high quality of **The Journal**. Keep up the good work.

Matthew Birch
New York, NY

Ed note: information packages are on the way.

Geneva khat researcher welcomes Gilbert column

I read and much appreciated the article on khat by Richard Gilbert (**The Journal**, April). I think it reflects the essential points of the subject very well and, of course, I am glad to see that the Kalix-Khan article he referred to had some echo at the Addiction Research Foundation.

Because of my interest in khat, I would be grateful if you could send, at your earliest convenience, a copy of the manuscript of the second part of the article, as well as two copies of **The Journal** of April 1.

Dr Peter Kalix
University of Geneva
Department of Pharmacology
Geneva, Switzerland

(Ed note: The material you requested is on its way.)

Icelandic writer wants more on troubled kids

Recently, I read in The Journal (January), about a program aimed at helping kids who can't say no to drugs. It's called Values, Influences and Peers (VIP).

Could you send me further information about this program (or send my letter on where it can be answered)? I am working with troubled kids, so this program could be of some help to me.

Thank you in advance.

Arni Einarsson
Reykjavik, Iceland

(Ed note: A copy of your letter has been forwarded to Jack Davis, education officer, Ontario ministry of education.)

Driver-kits interesting

I am writing to inquire about an article in **The Journal** (March) concerning a young-driver training kit. Could you provide me with the address of Alcohol and Drug Concerns, Inc so that I may obtain a sample of the kit?

I would appreciate any assistance you could give me. Also, keep up the good work. I enjoy **The Journal** very much.

Colin Campbell
Education Coordinator
Queens County Addiction Services
Alcohol and Drug Problems Institute, Inc
Charlottetown, PEI

(Ed Note: The address of Alcohol and Drug Concerns is: 11 Progress Ave, Suite 200 Scarborough, Ontario M1P 4S7.)

Send letters to: The Journal, 33 Russell St, Toronto, Canada M5S 2S1.

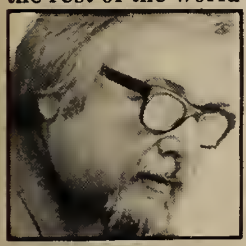
FEATURE

WHO fights world tobacco crosswinds

Maplines

GENEVA — The United Nations takes no moral position regarding smoking, nor is it "against" the tobacco industry. At the same time, its constituent World Health Organization (WHO) is extremely concerned about a massive surge in cigarette smoking in the developing world and concomitant diseases. In an epidemiological sense, the tobacco companies can be viewed as a vector, akin to the anopheles mosquito, the vector for malaria.

The multi-national tobacco industry is an integral part of the economic fabric of industrialized countries — in many of which the rate of cigarette smoking is dropping — and marketing of cigarettes in the rest of the world seems inexorable.



McConnell

In his final report from Geneva, contributing editor HARVEY McCONNELL talks to Roberto Masironi, MD, a senior medical officer at the WHO and currently coordinator of agency programs on smoking.

Dr Masironi points out that there are still wide discrepancies between the two worlds. In the industrialized world, the number of smokers has decreased during the past decade or so, but consumption among those who smoke averages 3,000 to 4,000 cigarettes (150-200 packs) a year. In developing countries, evidence indicates that the proportion of the population who now smoke is higher than in the industrialized world, but economic circumstances mean in many countries the average rate of consumption is as low as 200 cigarettes a year.

Medical problems associated with smoking are well known in the industrialized world. Officials know how to tackle them, and, in addition, there is a growing social resistance to smoking.

"But in developing countries, due to the pressure of the tobacco companies, smoking is seen as something desirable," Dr Masironi comments. "The tragic consequences will be that the diseases associated with smoking will increase in the countries which are least able to cope with huge medical problems."

Heart diseases, lung disorders and cancer, and chronic bronchitis caused by cigarette smoking will soon vie with the never-ending problems of endemic malnutrition and infectious diseases, plus cycles of drought or food and famine.

Cigarettes and alcohol in some ways go hand in hand: both are an immediate source of tax revenue for a government in which most members will not be around a decade or two later, when medical consequences surface.

Dr Masironi believes the problems are not insurmountable but do require imagination, married with goodwill. For example, tobacco is profitable only because farmers are paid to grow it — or not grow it — by government subsidy. On the other hand, the tobacco farmer has a ready market from the tobacco industry.

Profitable crop

The farmer who wants to make more money can grow a more profitable crop; but in many countries there are no supports, and farmers are left to cope with vagaries — of the weather, of finding a market. Crops are often perishable.

The UN's Food and Agricultural Organization and the World Bank have clearly stated they will give assistance to countries wishing to have farmers diversify out of tobacco production.

The lure in most developing countries is from the Western name brand cigarette: residents could consume far more local products, but they don't seem to want to. Western cigarettes can cost 10 times more than local cigarettes, but they carry prestige.

In developing countries, cigarettes are promoted, as is alcohol, as a status item. "You see the finesse of their advertisements on hoardings and billboards; there are always appeals to status, sex, and the idea of success," Dr Masironi observes.

"They are much more crude in the developing countries than here (Switzerland), where the appeal is to the beauty of nature, or the meaningless imagery of the non-existent cowboy."

Many countries have tightened their laws on cigarette advertising, but the multi-national tobacco companies are adroit in their response. Instead of showing cigarettes, they display a cigarette lighter, or goods are named after cigarettes.

"The trend toward increased cigarette consumption is there in the developing countries," according to Dr Masironi. "As the earning power of the people increases, the number of cigarettes smoked will increase." At the same time, tobacco companies are preparing for this new market, to compensate for the long-term decrease in their market in industrialized countries.

It will be an uphill battle, "perhaps more difficult than any other health-oriented battle," and it may be more difficult than combating alcohol and other drug use.

Large majority

Dr Masironi: "By and large, a great majority of people enjoy drinking a little alcohol, and without any serious consequences. There are hundreds of millions of people who don't drink at all. There is a consistent fight against illicit drug use.

"With centuries-old endemic diseases, everyone, the government and people, are with us; we have to fight malaria, we have to fight smallpox. Even if it is difficult, everyone is with us.

"Smoking is the other way around. It is still a socially acceptable drug, and governments are against any kind of anti-tobacco, health-oriented action because of the money cigarette sales bring in. Most ministers of health, although not all, are in the anti-smoking camp, but most other departments of government are in favor of tobacco because of the revenue generated by its sales."

Allied with the government interests are those of many smokers, who are against any action. "So it is both an economically and politically difficult battle," Dr Masironi states.

Unabated spread

Action is needed against an unabated spread of tobacco because calculations show there will be a tremendous increase in lung cancer cases, heart attacks, and other debilitating diseases associated with smoking. Educational programs and action by the media and legislators take time.

Dr Masironi says the WHO fills a critical need by publishing objective information and data. "This is useful in strengthening government resolve. If they can point out 'the WHO says this or that,' then they can feel confident as well, in initiating whatever action they think best."

A number of WHO-supervised seminars are held in developing countries in an effort to increase the awareness of the general population about smoking-associated problems. Many seminars are attended by the relevant minister of health, which demonstrates some official support for anti-smoking action.

The areas with the most pressing problems at the moment are South America and China, Dr Masironi considers.

In South America, there has been a large increase in smoking, and there is a much larger urban concentration of people and power than in Africa. This does not mean the gap cannot be closed quickly; a paucity of money to purchase cigarettes may have caused Africans to lag behind, but cigarette sales are increasing, and cigarette-selling to young people is widespread.

China has a history of smoking, and today officials realize the local product is not good enough. The government has entered into joint ventures with the United States tobacco industry to build new factories and to increase cigarette production.

Dr Masironi says that while such production will mean a tremendous source of revenue for the government, officials are not blind to the health problems which will be posed.

Faced with the prospect of billions and billions of cigarettes in the developing world, and a pack for every pocket, the only rational objective now is to try and keep the status quo.

Dr Masironi adds: "This, again, underlines the importance of fighting against the advertising techniques of the tobacco industry. The industry says advertising is not influencing people to smoke but only to shift brands. This is not so. If it were a matter of shifting brands . . . they would not spend two billion dollars a year in advertising."

Over time, people subconsciously accept smoking as part of the social fabric. Nice young people are seen to smoke. Many other people may not take up smoking, but they will have a favorable attitude.

At the moment, for a variety of social, religious, or economic reasons, few women in the developing world smoke. An exception is Nepal, and nobody knows why.

Dr Masironi declares that one must fight "the subtle psychological kind of brain washing about smoking, because if it is not stopped it inevitably will mean that women in the developing countries will look at smoking as something favorable or desirable. This is something we have to stop."

NEWS AND DEPARTMENT

New Brunswick plans to enhance staff skills

FREDERICTON — A program designed to upgrade or enhance the skills of staff working in treatment programs of the New Brunswick Alcohol and Drug Dependency Commission (ADDC) recently saw 16 nurses, counsellors, and attendants receive certificates for successful completion of its second stage.

ADDC Chairman G. Everett Chalmers, MD, told participants in the counselling skills program that under the Commission's team approach, staff require more education, counselling skills, and training in order to facilitate the ADDC's multi-disciplinary strategy.

He said one of the objectives of the Community Services Division is to change the attitude of professionals and the general public by demonstrating that "alcohol and drug abuse is not harmless, but can cause serious physical and mental health problems — and can even destroy families and individuals."

Dr Chalmers said employee assistance programs, programs for motorists and others ensnared in the justice system because of use or abuse of alcohol, and programs for university students, never seem to end. "They are all aimed at making the public more aware of the seriousness of alcohol and drug abuse."

He noted improvements in treatment and rehabilitation programs since the ADDC came into being in 1978. Then, he said, "we were only looking after the derelict-chronic alcoholics who were all males and on social assistance. Today, 50% of those going through our detox centres have jobs, and 60% going through rehabilitation programs are working." The number of female patients has increased noticeably since 1978.

The ADDC staff previously completed the first phase, Core Knowledge in the Addiction Field, and the final part of the program will be specialized instruction in prevention.

New Books

by RON HALL

Your Teen and Drugs: A Parent's Handbook on Drug Abuse

. . . by Norman Panzica

This work is based on the 40 questions most frequently asked by parents attending the author's seminars. Historical background is presented and the development of drug use is traced through the 50s and 60s. Profiles of drug users and a description of addiction are provided. A chapter focuses on marijuana, describing its effects, legalization, comparison with alcohol, and as a stepping stone to other drug use. Recognition and prevention of drug abuse are discussed and a chapter is devoted to coping with the teen on drugs. The concluding chapter provides answers to specific questions such as: What if my child is arrested on a drug charge? How do you handle a teenager who refuses parental help? Where do teenagers get the money to buy drugs?

(McGraw-Hill Ryerson Limited, 330 Progress Ave, Scarborough, ON, 1983. 164p. $9.95 ISBN 0-07-548591-5)

Marijuana Alert

. . . by Peggy Mann

The book is divided into three sections: the crisis, the health hazards, and what is being done about the marijuana epidemic. The first part provides statistical and other data to illustrate the extent and impact of the use of marijuana: in the workplace, in the armed forces, and in the school system. The second part of the book provides an overview of health hazards by explaining what marijuana is and what it does, physiologically and psychologically. The effects of marijuana on the lungs and heart are explained through scientific studies. Other chapters are concerned with the effects on: sex and reproduction, the brain, the immune system, other cellular effects, and psychologically. A chapter is devoted to a discussion of marijuana as a medicine, and another presents information on marijuana and driving. In the third section, the author looks at what is being done about the situation. The United States federal strategy is to attack demand and supply. Marijuana detection tests are discussed as being an important "weapon" in the battle against drug abuse. Action in the school system outlines examples of several successful programs. US Armed Forces programs are described, as are several programs focusing on the workplace. Finally, a chapter is devoted to the present movement for drug-free youth.

(McGraw-Hill, New York, NY. 1985. 526p. $10.95. ISBN 0-07-039906-9)

Others books

Establishing and Building Employee Assistance Programs—Myers, Donald W. 1984. Troubled employee; problem areas; deficiencies; program models; strategic planning; personnel manager and employee assistance programs (EAPs), counselling applications in personnel management; counsellor linkages and roles; selecting a counsellor; increasing counsellor effectiveness, increasing referrals; EAP committees; evaluation; index. 335 p. Quorum Books, 88 Post Road W, Box 5007, Westport, CT 06881. $39.95. ISBN 0-89939-044-8.

Occupational Alcoholism: An Annotated Bibliography — Kurtz, N.R.; Googins, B.; and Howard, W. Addiction Research Foundation, Toronto, 1984. Contains citations and annotations of 481 papers; organized under 20 subject headings. 218p. Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell St, Toronto, ON M5S 2S1. $15. ISBN 0-88868-101-1.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:

a) Regular Line Rates	$1.09 line
b) Standard Units of Insertion	
1 Page (1,120 lines)	$1,000
½ Page (560 lines)	$500
¼ Page (280 lines)	$250

c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation 27,318 (Canada, 21,412, USA 1,907, Foreign, 386, Bulk, 3,613)
Media 2,264

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents $16 per year
US & Foreign Residents $24 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount
Ontario residents billed as other Canadians

The Journal, 33 Russell St
Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

Youth: alcohol and other drug use in Canada

Manuella Adrian, head, statistical research program, Addiction Research Foundation, based Stats • Facts on: Statistics on Alcohol and Drug Use in Canada and Other Countries, Volumes 1 and 2 (based on data available by September, 1984).

Alcohol

At what age are Canadians allowed to drink?

The legal drinking age in most of Canada is 19 years. It is 18 years in four provinces: Prince Edward Island (PEI), Quebec, Manitoba, and Alberta. A 1983 national Gallup survey shows that 62% of the population favors a national law that would raise the legal drinking age in all provinces to 21 years. This attitude was shared by only 49% of people aged 18 to 29.

How many underage Canadians drink?

According to a 1982 national survey, 64% of teenagers aged 12 to 19 years, or 2.2 million teenagers, drank at least once in the previous year. The percentage of teenage alcohol users varies somewhat from province to province, reaching a high of 80% in Nova Scotia (NS) in 1979, and a low of 46% in New Brunswick (NB) in 1976 (based on use in the previous six months).

How many young adults drink?

A 1983 national Gallup survey indicates that 83% of people aged 18 to 29 years (or 4.7 million young adults), have ever had occasion to use alcoholic beverages. The percentage of users differs slightly from province to province, being 90% in Ontario (1984). Sixty-four percent of Ontarians aged 18 to 29 years drink five drinks or more at a single sitting. Fifty-four percent report becoming "high" or "tight."

How many juveniles contravene alcohol-related legislation?

In 1982, 11,650 juveniles were charged with criminal offences under provincial liquor control acts. A juvenile is a person under the age of 16 years (under 17 years in Newfoundland and British Columbia (BC), and under 18 years in Quebec and Manitoba). There were 7,239 alcohol-related juvenile delinquencies (or 6% of all juvenile delinquencies) for which court action was terminated in 1981; 5,742 were found guilty as charged.

According to 1979 Ontario court data, 35% of all convictions for alcohol-related driving offences (driving while impaired, having a blood alcohol level in excess of .08 mg/100 ml blood, or refusing to provide a breath sample) occur in people aged 16 to 24 years. This age group accounts for 50% more than the average rate of traffic convictions for all age groups combined.

How many young people have alcohol-related health problems?

In 1980-81, in general hospitals in Canada, there were 3,158 people between the ages of 10 and 24 years treated for alcohol-related problems consisting of: alcohol dependence syndrome, non-dependent abuse of alcohol, toxic effects of alcohol, and chronic liver disease and cirrhosis. The age group 10 to 24 years had a 50% higher rate of toxic effects of alcohol, and a 30% higher rate of non-dependent abuse of alcohol than the average rate for all age groups combined.

In 1981-82, in mental hospitals in Canada, there were 389 people treated for alcohol-related problems consisting of alcohol dependence syndrome and alcohol psychoses.

A 1982-83 survey of all types of alcohol treatment services in Ontario indicated that there were 3,533 people aged 18 years and under treated for alcohol-related problems. Treatment was provided in detox centres and in hospital- and community-based residential and non-residential facilities. Young people aged 18 and under were primarily treated in non-residential facilities. The rate for people 18 years and under treated in hospital non-residential facilities is 80% greater than for the general population, and it is 35% greater for treatment in community-based, non-residential facilities.

How many youngsters die of alcohol-related disorders?

In 1982 in Canada, there were 22 deaths in the 15- to 24-year age group from alcohol-related diseases consisting of toxic effects of alcohol (11 deaths), non-

STATS·FACTS

Youth: alcohol and other drug use in Canada

(continued from page 11)
dependent abuse of alcohol (five deaths), chronic liver disease and cirrhosis (five deaths), and alcohol dependence syndrome (one death).

Tobacco

How many young people smoke?

According to a 1978 survey, 53% of Canadian school children in grades 3 and up (including elementary and secondary schools) had ever tried smoking or smoked. Thirteen percent were daily smokers. Smoking increases with increasing age. At age eight, only 17% have ever smoked; by age 16, 70% have smoked. Daily smoking increases from 1% in 11 year olds to 30% among those 19 years and older.

Tobacco use among high-school students varies from province to province, from a low of 29% in Ontario (1983) for use in the past 12 months, to a high of 50% in PEI (1982) for use in the past six months.

How many young adults smoke?

According to a 1983 national Gallup survey, 46% of Canadians aged 18 to 29 years used cigarettes in the week before the survey.

Other drugs

What is the most-used drug?

Cannabis.

According to a national Gallup survey in 1982, 19% (or two-thirds of a million Canadian teenagers aged 12 to 19 years) indicated that they had used marijuana at least once in the previous 12 months.

Cannabis use varied from a high of 44% in Nova Scotia (1979), based on use in a six-month period, to a low of 19% for marijuana and 15.5% for hashish in Quebec (1975), based on use in a 12-month period. In Ontario, 24% of high-school students surveyed in grades 7, 9, 11, and 13 reported they had used cannabis in the previous 12 months (1983).

Among young adults aged 18 to 29 years, marijuana was used by 28.5% (or an estimated 1.6 million young Canadians) based on a 1984 Ontario survey.

How many juveniles were involved in cannabis-related crime?

There were 2,443 juveniles charged with cannabis-related criminal offences (1982). In addition, there were 2,020 cannabis-related juvenile charges for which court action was terminated in 1981.

How many use barbiturates?

Use of prescription barbiturates and other sedatives, hypnotics, and depressants by students ranged from a low of 1% for Manitoba (1978), to a high of 11% for Ontario (1983) for prescription barbiturates. Six percent of Ontario students reported using non-prescription barbiturates.

Among young adults aged 18 to 29 years, 2.2% used sleeping pills (based on a 1984 Ontario survey).

How many use tranquillizers?

Tranquillizer use by students ranged from a low of 2% in PEI (1982) and Manitoba (1978), to a high of 10% in NS (1979). Five percent of Ontario students used non-prescription tranquillizers (1983).

Among those 18 to 29 years in Canada, 3.6% used tranquillizers (based on a 1984 Ontario survey).

How many use stimulants?

Use of stimulants by students ranged from a low of 1% in PEI (1978), to a high of 15% for non-prescription stimulants in Ontario (1983). Five percent of Ontario students reported use of prescription stimulants.

Among young people aged 18 to 29, 5% (or an estimated 300,000 Canadians) used stimulants (Ontario survey 1984).

How many use inhalants?

Inhalant use ranged from 1% in NB (1976), to 6% in NS (1979) and BC (1982).

How many use hallucinogens?

Hallucinogen use by students ranged from a low of 3% reported in Manitoba (1978), to a high of 12% in BC (1982).

LSD use by high-school students ranged from 3% in Quebec (1975) and in PEI (1982), to a high of 9% in Ontario (1983).

PCP (phencyclidine) use ranged from 1.4% in PEI (1982) to 2% in Ontario (1983).

Seventy-three percent of all new hallucinogen drug users were under age 25 (1982).

How many juveniles were involved in hallucinogen-related crimes?

There were 127 juvenile delinquencies involving LSD, MDA, and PCP for which court action was completed in 1981.

How many use opiates?

Opiate use reported by students ranged from a low of 0.5% for heroin in Quebec (1975), to a high of 3% in New Brunswick (1976).

How many use cocaine?

Cocaine use by students ranged from 1.6% in Manitoba (1978), to 7% in BC (1982).

Among young adults aged 18 to 29 years, cocaine was used by 7% (or an estimated 400,000 Canadians) based on a 1984 Ontario survey.

How many young narcotic drug users are there?

There were 2,277 illicit narcotic drug users under age 25, or 16% of all users, coming to the attention of the Bureau of Dangerous Drugs (1982).

How many juveniles were involved in drug crimes?

In 1982, there were 2,698 juveniles charged with drug-related criminal offences, including cannabis offences noted above.

There were 2,481 juvenile offenders for whom court action was terminated in 1983; 75% were found delinquent after adjudication.

How many were sent to jail for drug offences?

There were 560 admissions of people under age 25, or 73% of all drug admissions, consisting of offences under the Narcotics Control Act, to provincial/territorial adult correctional facilities which hold prisoners sentenced for less than two years.

In addition, people under the age of 25 years accounted for 99 drug-related admissions to Canadian penitentiaries, or 22% of all drug admissions (1979). Canadian penitentiaries hold prisoners sentenced for two years or more.

How many young people have drug-related health problems?

In 1980-81, in general hospitals in Canada, there were 5,891 people aged 10 to 24 years treated for drug-related problems consisting of: drug psychoses, drug dependence, non-dependent abuse of drugs, and poisonings from analgesics, sedatives and hypnotics, and psychotherapeutic drugs. This age group had a 50% higher rate of drug psychoses, non-dependent abuse of drugs, and poisonings by salycilates than the average rate for all age groups combined.

In 1981-82, in mental hospitals in Canada, there were 454 cases treated consisting of: drug psychoses, drug dependence, and non-dependent abuse of drugs. This age group had a 50% higher rate of these disorders than the average rate for all age groups combined.

In 1982, poison control centres documented 1,101 cases involving people aged five to 14 years and 1,619 psychoactive drugs involved in these cases.

How many youngsters die of drug-related disorders?

In 1982 in Canada, there were 65 deaths from drug-related diseases consisting of: drug dependence, non-dependent abuse of drugs, and poisonings from analgesics, sedatives and hypnotics, and psychotherapeutic drugs.

These data are based on administrative reporting systems, or on surveys of the general population. Estimates based on surveys are approximate figures only. The real figures may be slightly smaller or larger.

* * *

Readers requiring other Canadian statistics are invited to write to The Journal, *33 Russell St, Toronto, Canada M5S 2S1. Questions will be addressed, from time to time, in forthcoming editions of* The Journal.

Secretary-General Perez de Cuellar a catalyst

Non-government drug committees form at UN

By Lynn Payer

UNITED NATIONS, NY — The recently-formed Non-Governmental Organizations (NGO) Committee on Narcotics and Substance Abuse here can play a key role in raising consciousness about drug abuse issues, says Donald Fitzpatrick, a committee founder and special assistant for political and humanitarian affairs to United Nations Under - Secretary - General William Buffum.

"The committee can provide the expertise and views on subjects it would take governments years to agree on because of political considerations," Mr Fitzpatrick told **The Journa**l.

The NY committee, formed in December 1984, is expected to be action-oriented, and has representatives from 24 international non-governmental organizations. A parallel committee in Vienna was formed in 1983.

Mr Fitzpatrick said the NY committee resulted from the particular interest in the drug problem of UN Secretary General Javier Perez de Cuellar. Last November, Mr Perez de Cuellar became the first UN secretary general to address the human rights committee on the topic of drug control. In May 1984, he had appointed Mr Buffum coordinator of all UN drug control activities.

The growing concern about drug control in a number of countries was another reason the NY committee was formed, Mr Fitzpatrick said. He noted Mr Perez de Cuellar had found in meetings that nearly all heads of governments wanted to discuss drug problems in their countries.

Committee members are now in the process of "educating ourselves on what the issues are," said Michael Jupp, UN representative of Defense for Children International and chairman of the NGO committee.

He told **The Journa**l the committee is reviewing research by NGOs on crop substitution, treatment of drug use, and drug education. A study of 800 voluntary agencies has begun, to discover what is being done about the drug problem, and the committee hopes to be able to draw some conclusions by the end of 1985.

Mr Jupp said he is particularly interested in nontraditional approaches to drug abuse problems. "Laws as far back as 1896 have been trying to stop the international drug trade," he commented, a fact "which makes one wonder if traditional methods are effective."

The problem must be treated internationally, he said, taking account of all of the effects of drugs on people. "Some people actually owe their survival to the drug trade," he noted.

Members of the NGO committee are: American Association of University Women; Baha'i International Community; Brahma Kumaris World Spirituality University; Defense for Children International; Gray Panthers; International Advertising Association; International Catholic Child Bureau; International Centre of Social Gerontology; International Council of Women; International Probation, Parole and Correction; International Social Service; JCs International; Lion's International; Movement for a Better World; Salvation Army; Servas International; Soroptimist International; UN International Business Council; Women's Christian Temperance Union; Women's International League for Peace and Freedom; World Assembly of Youth; World Baptist Alliance; World Union of Catholic Women's Organizations; and World Union for Progressive Judaism.

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Drugs, Drinking, Driving (2nd Edition)

Number: 633.
Subject heading: Impaired driving.
Details: 15 min, color.
Synopsis: Driving while intoxicated on any drug can be dangerous — even small amounts of some drugs can impair a driver, as shown by three separate incidents. Carl's wife unsuccessfully tries to persuade him not to drive after drinking at his brother's barbeque; the resultant accident kills both her and their daughter. Mike and his girlfriend, after having a few drinks and a "joint" have an accident on their way home. In a third scene, Linda takes an extra dose of antihistamines for her flu; she loses control of her car, killing a pedestrian.
General evaluation: Good (4.1). This film had a clear message, although there was no information about how to handle situations involving the use of drugs and cars.
Recommended use: General audience.

Stop and Think: The Ad Game

Number: 632.
Subject heading: Alcohol and youth, drugs and youth.
Details: 1-16 mm, 22 min — 1 filmstrip, 5 min.
Synopsis: In the film segment of this program, a young man talks to a class about his experiences with alcohol; several young women discuss the reasons why they want to continue using drugs; a principal tells about drug-induced incidents in his school. Interspersed between these stories is a dramatic accident scene involving emergency crews trying to save the lives of two young people trapped in a wrecked car. An accompanying filmstrip satirizes those beer ads that imply that it is manly or sexy to drink.
General evaluation: Good to very good (4.8). This contemporary, well-produced package had a clear message that could lead to attitudes opposed to drug abuse.
Recommended use: With a resource person, would benefit audiences aged 12 to 18 years.

Junkie

Number: 648.
Subject heading: Women and drugs.
Details: 58 min, color.
Synopsis: A group of women who have had addiction problems have gathered in a studio to make a film about their experiences. Through role-playing, they tell how compulsive behaviors involving dieting, eating, shopping, and use of drugs, affected them and the people around them.
General evaluation: Fair to good (3.5). This well-produced film had great emotional impact. However, it was considered too lengthy.
Recommended use: With a resource person, this film could benefit women in treatment.

Epidemic: America Fights Back

Number: 649.
Subject heading: Community development.
Details: 28 min, color.
Synopsis: There has been a epidemic of drug use among young people in the United States, and statistics tell of many tragedies. However, throughout the US, parents' groups, schools, and community action groups are organizing to educate themselves and fight back. Three programs are discussed to show what can be done to turn the problem around.
General evaluation: Fair (3.4). This film was a good teaching aid but of poor technical quality.
Recommended use: With a resource person, it could be used by parents, community, and school groups.

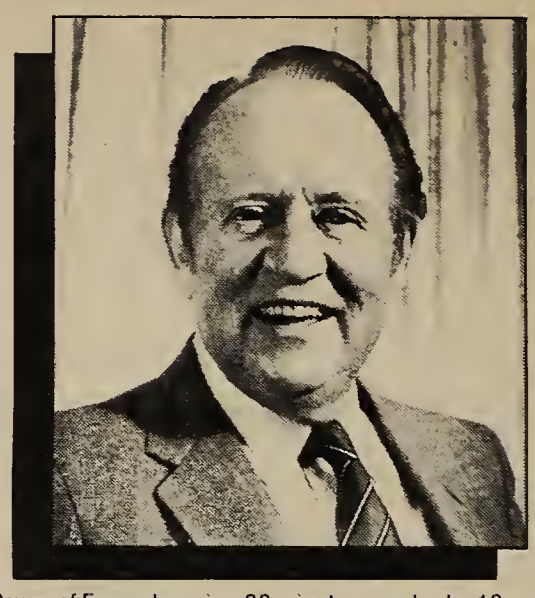
My 5th Superbowl

Number: 647.
Subject heading: Drugs and sports.
Details: 32 min, color.
Synopsis: Carl Eller played professional football for many years and was in the Superbowl four times. However, during the off-season and then later, even while playing, Mr Eller abused drugs. He recounts his experiences with many different drugs, and how they affected his life, his marriage, his athletic and business careers, and his relationships with others. He is now trying to stay drug-free.
General evaluation: Good to very good (4.5). In his lecture, Mr Eller came across as knowledgeable and caring. The technical quality was good, and the assessment group thought Mr Eller's use of a chart helped explain the concepts well.
Recommended use: This film would be beneficial to those 12 years and older.

The Young Alcoholic: A Family Dilemma

Number: 651.
Subject heading: Treatment/rehabilitation, public relations.
Details: 28 min, color.
Synopsis: Families experiencing problems because of a teenage drinker seek help from the Maxwell Institute. They are given a series of lectures about alcohol abuse and how to confront the alcohol abuser. The family members practice confrontation in preparation for convincing the abuser to enter treatment. One family discusses how they sought and received help for their problems.
General evaluation: Poor (2.3). The assessment group took exception to the overly formal style of the lecturer, and was concerned about such a powerful confrontation procedure and its possible negative consequences, especially if attempted by untrained people.
Recommended use: With a resource person, this film could be used as a public relations tool for the Maxwell Institute.

ART LINKLETTER ANNOUNCES A NEW STAR-STUDDED ANTI-DRUG MOTIVATIONAL FILM "MENTORS...The Power of Example"



"MENTORS" — The Power of Example — is a 26 minute, sound color 16 mm film for grammar and junior high school students that takes a very different approach in dealing with the drug and alcohol crises that plagues young people everywhere. Unlike other films that deal in scare tactics, MENTORS takes a positive approach. Instead of generating fear, it motivates, instead of preaching, it inspires. The stars in this film talk to the kids on their level, about the problems they themselves had growing up, facing the same peer pressures and fears that kids today are going through.

— ART LINKLETTER

Steve Garvey — All-Star First Baseman for the San Diego Padres and voted MVP of the National League Playoff Championships.

Kim Fields — Stars as "Tootie" in the NBC Hit TV Series "Facts of Life."

Steven Young — All-American Quaterback for the USFL's Los Angeles Express football team.

Laura Branigan — Top rated pop-rock singer, and superstar remembered for her hit "Gloria" and her best-selling record, "The Lucky One."

Steve Sax — All Star Second Baseman for the L.A. Dodgers, and national MENTORS chairman.

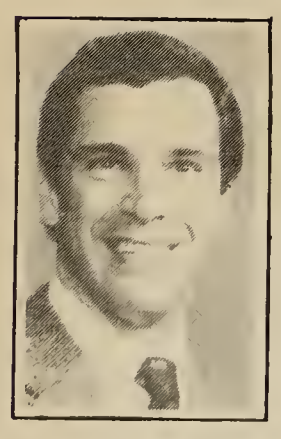
Jennilee Harrison — Of the TV Sitcom "Three's Company" fame and currently starring in "Dallas."

One of law entorcements toughest jobs is dealing with drugs and the tragedies it causes amoung our young people. I salute Steve Garvey and everyone who made the MENTORS tilm available to the kids. It is these kinds of efforts that might save our future generation trom this kind of tragedy.

— DARYL GATES
Chief, Police Department, Los Angeles, CA

The MENTORS film is right up-to-date in its appeal to junior high school kids. The old "scare tactics" just did not work. The old "THOU SHALL NOT" set of rules is passe. The kids just love the introduction to positive steps and attitudes. It works.

— DON SMYTHE, M.S.
Alcohol & Drug Abuse Consultant
Ottawa School Board, Ottawa, Canada



On behalf ot our students, taculty and staft, I would like to thank you for making the MENTORS film available to us. The entire student body viewed the movie and did come away with positive impressions. If you would like additional comments concerning the film, please contact me.

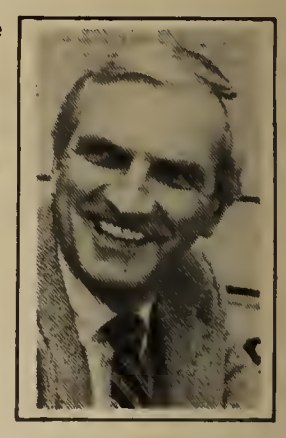
— JEFFERY F. ZACKON
Principal
S.S. Palmer Middle School
Palmerton, Pennsylvania

As a professional coach I've learned that fear is not a way of changing behavior — but motivation is. My only fear was of losing and a fear of failure. That fear itself becomes a motivation. I applaud producer Michael Radford and all those associated with the MENTORS film.

— GEORGE ALLEN
Chairman, President's Council on Physical Fitness

Speaking personally, I think the MENTORS film is excellent. It is a perfect tool for a teacher in grades 7 and 8 to promote meaningtull discussions about today's life styles and in developing future value systems.

— GORDON MUTTER, Ph.D.
Chiet, Education & Training Unit
Health & Welfare, Canada



What an exciting film to share with students. "Mentors" will stimulate discussions about real lite issues, how to make important decisions and values worth cultivating. The classroom teacher will find the students asking to see this film again.

— CAROL McDILL, R.N., M.F.C.C.
Lucia Mar School District Nurse
Arroyo Grande, California

MENTORS is a good way of presenting drugs and alcohol to early drug education groups. Adolescent problems are well presented and an optimistic feeling flows throughout the movie. It's catchy and very upbeat.

— MAURICE VILLENEUVE —
Consultant, Addiction Research Foundation
Ottawa, Canada

The concepts behind the MENTORS film are sound principles advocated by most health and drug authorities. Prevention is the simplest and most cost efficient, however it can not be shouldered by the schools alone, it is a task tor the entire community.

— MARY ANN STOCKER, R.N., M.S.
Drug Resource Specialist
Manatee County, Florida

We have previewed the MENTORS film and find that it would serve as an excellent review ot the concepts taught in our Operation Aware Program. We will recommend this tilm in our next Newsletter which is mailed to all teachers and counselors who are teaching our program in their respective schools.

— SISTER MARILYN MICKE
Administrator, Operation Aware, Inc.
Duluth, MN

SPECIAL 50% DISCOUNT

The MENTORS film regularly sells tor $790, however there is a special 50% discount available only to non-profit organizations (schools, drug prevention agencies, service, civic, fraternal, veteran and governmental organizations) — or for private individuals or companies who wish to buy the film for direct shipment to a non-profit organization. The discount applies only when the 26 minute, 16 mm, sound color print of the MENTORS film is ordered directly from the non-profit MOTION PALPATION INSTITUTE, and payment of $395 is received in U.S. Funds, plus any sales taxes that may be due. Upon receipt of payment in full, the tilm will be shipped anywhere in North America freight prepaid. Buyer acknowledges that as a condition of purchase it will not allow the MENTORS film to be copied in any tashion, nor is it licensed to be shown on any form of television. The U.S. Intormation Agency of the U.S. Government has formally certified the MENTORS film as "educational" which means it will pass through foreign customs almost everywhere in the world without any "hang ups" and with little or no duty.

TO ARRANGE A PREVIEW SHOWING OF MENTORS...The Power of Example

PLEASE CALL A DOCTOR OF CHIROPRACTIC IN YOUR COMMUNITY

MENTORS...A MICHAEL RADFORD PRODUCTION
is sponsored as a community service by the non-profit

MOTION PALPATION INSTITUTE
21541 Surveyor Circle (P.O. Box 6100)
Huntington Beach, CA 92646 USA
(714) 536-7553 or (714) 960-6577

To: MPI: P.O. Box 6100, Huntington Beach, CA 92615 USA

Enclosed please find our check for $395 (U.S. funds). Please ship our print of the Mentors film together with the Special Teacher/Counselor Guide freight prepaid.

_____
NAME OF THE NON-PROFIT ORGANIZATION

Address _____

City _____ State/Province _____ Mail/Zip Code _____

Telephone ( ) _____ Ext _____

Ordered By _____

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

85th Annual Meeting of the Canadian Lung Association, and the annual scientific meetings of the Canadian Nurses' Respiratory Society, and the Physiotherapy Section of the Canadian Lung Association — June 1-5, Ottawa, Ontario. Information: A. Les McDonald, health education coordinator, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, ON K1P 5E7.

Medic Canada 85 — June 3-5, Toronto, Ontario. Information: Medic Expositions of Canada Inc, 67 Mowat Ave, Ste 242, Toronto, ON M6K 3E3.

Public Interaction in Health Care — June 7, Toronto, Ontario. Information: Professional and Management Development, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Child Abuse Conference — June 13-14, Toronto, Ontario. Information: Ingrid Norrish, program manager, Professional and Management Development, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Canada Safety Council 17th Annual Conference — June 23-26, St John's, Newfoundland. Information: Canada Safety Council, 1765 St Laurent Blvd, Ottawa, Ontario K1G 3V4.

Management for Supervisors in the Health Care Setting — July 3-4, Aug 19-20, Toronto, Ontario, Aug 13-14, Edmonton, Alberta, Aug 15-16, Saskatoon, Saskatchewan. Information: Professional and Management Development, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

International Convention of Alcoholics Anonymous — July 4-7, Montreal, Quebec. Information: International Convention, Box 1985, Station D, Buffalo, New York 14210.

Management II for Supervisors in the Health Care Setting — July 5, Toronto, Ontario. Information: Professional and Management Development, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

26th Annual Institute on Addiction Studies — July 14-19, Hamilton, Ontario. Information: Kathryn Irwin, course administrator, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer School For Addiction Studies — July 15-26, Toronto, Ontario. Information: Doreen Ross, School For Addiction Studies, Addiction Research Foundation (ARF), 8 May St, Toronto, ON M4W 2Y1.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-10, Calgary, Alberta. Information: Jan Skirrow, chairman, 34th ICAA Congress, AADAC, 6th floor, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

Canadian Addictions Foundation Annual General Meeting — Aug 5, Calgary, Alberta. Information: Leona Gallinger, Canadian Addictions Foundation, Pacific Plaza, Box 702, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

23rd Annual Summer Conference of the International Transactional Analysis Association (ITAA) — Aug 8-11, Toronto, Ontario. Information: Dale Perrin, 2055 Dundas St E, Ste 104, Mississauga, ON L4X 1M2.

10th International Congress of Hypnosis and Psychosomatic Medicine, Introductory and Specialized Workshops and Scientific Program — Aug 10-16, Toronto, Ontario. Information: 10th International Congress Secretariat, 200 St Clair Ave W, Ste 402, Toronto, ON M4V 1R1.

Royal College of Physicians and Surgeons of Canada — 54th annual meeting — Sept 9-12, Vancouver, British Columbia. Information: Robert A. Davis, coordinator, Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

The Canadian Thoracic Society and the Medical Section of the Canadian Lung Association, conjointly with the Royal College of Physicians and Surgeons — Sept 9-12, Vancouver, British Columbia. Information: A. Les McDonald, health education coordinator, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, ON K1P 5E7.

Annual Meeting of the Canadian Society of Forensic Science — Sept 20-27, Montreal, Quebec. Information: executive secretary, Canadian Society of Forensic Science, 2660 Southvale Cres, Ste 215, Ottawa, Ontario K1B 4W5.

Ontario Public Health Association 36th Annual Educational and Scientific Meeting — Sept 22-25, Toronto, Ontario. Information: Ontario Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, ON K1Z 8N8.

Canadian Association on Gerontology, 14th Annual Scientific and Educational Meeting — Oct 17-20, Hamilton, Ontario. Information: CAG 85, PO Box 1002, McMaster University, Hamilton, ON L8S 1C0.

Productivity 85 (EAP) — Oct 23-24, Saskatoon, Saskatchewan. Information: Personnel Performance Consultants, Box 7811, Saskatoon, SK S7K 4R5.

Input 85 — The 6th Biennial Canadian Conference on Employee Assistance Programs in the Workplace — Oct 27-30, Ottawa, Ontario. Information: Input 85 Headquarters, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Northern Youth in Crisis: A Challenge For Justice — Nov 3-8, Val d'Or, Quebec. Information: Northern Conference Office, c/o Continuing Studies, Simon Fraser University, Burnaby, British Columbia V5A 1S6.

1985 Ontario Occupational Health Nurses Association Conference — Nov 4-8, Toronto, Ontario. Information: B.J. Varey, RN, CCOHN, publicity committee chairperson, c/o Sun Life of Canada, 3rd fl, 150 King St W, Toronto, ON M5H 1J9.

Skill Training for Employee Assistance Personnel — Nov 17-21, Oakville, Ontario. Information: James Simon, Peel Centre, ARF, 39 Dundas St E, Ste 203, Mississauga, ON L5A 1V9.

23rd Annual Scientific and Business Meeting — Nov 27-30, Toronto, Ontario. Information: Ontario Chapter College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

Symposium 86: Focus on the Family — Jan, 1986, Toronto, Ontario. Information: Gilda Ennis, Metatron, 53 Lisa Cres, Thornhill, ON L4J 2N2.

International Association of Forensic Sciences 11th Meeting — Aug 2-7, 1987, Vancouver, British Columbia. Information: International Association of Forensic Sciences, 801-750 Jervis St, Vancouver, BC V6E 2A9.

United States

International Summer School on Chemical Dependency and the Family — June 3-6, Moorhead, Minnesota. Information: Debby Thornton, CD school secretary, department of social work, Moorhead State University, Moorhead, MN 56560.

6th Annual National Conference on Employee Assistance Programming — June 3-6, Kansas City, Kansas. Information: Bethany Medical Center, The National EAP Conference, 51 North 12th St, Kansas City, KS 66102.

Treating Family Systems — Advanced Techniques — June 6-7, Mount Vernon, Illinois and Elgin, Illinois. Information: Collen Rabelow, department of health education, Southern Illinois University, Carbondale, IL 62901.

Committee on Problems of Drug Dependence 47th Annual Scientific Meeting — June 10-12, Baltimore, Maryland. Information: Dr Joseph Cochin, executive secretary, Committee on Problems of Drug Dependence, department of pharmacology, Boston University School of Medicine, 80 East Concord St, Boston, Massachusetts 02118.

Financial Management and Legal Issues for Health Care Administrators — June 12-14, Center City, Minnesota. Information: Hazelden, Box 11, Pleasant Valley Rd, Center City, MN 55012.

Women for Sobriety — June 14, Chicago, Illinois; June 17, St Louis, Missouri; June 19, Kansas City, Missouri; June 21, Denver, Colorado; June 26, Albuquerque, New Mexico. Information: Women for Sobriety, Inc, PO Box 618, Quakertown, Pennsylvania 18951.

16th Annual International Narcotic Research Conference — June 23-28, Seacrest, Massachusetts. Information: E. Leong Way, PhD, department of pharmacology, University of California, San Francisco, CA 94143.

Rutgers Summer School of Alcohol Studies 1985 — June 23-July 12, Piscataway, New Jersey. Information: Gail Milgram, Education and Training Division, The State University of New Jersey, Rutgers Center of Alcohol Studies, Smithers Hall, Piscataway, NJ 08854.

36th Annual Symposium on Alcoholism — June 24-July 5, Seattle, Washington. Information: Alcohol Studies Program, Seattle University, Seattle, WA 98122.

National Federation for Specialty Nursing Organizations — June 28-29, Chicago, Illinois. Information: National Nurses Society on Addictions, 2506 Gross Point Rd, Evanston, IL 60201.

14th Annual San Diego Summer Alcohol and Drug Studies Program — July 8-12, La Jolla, California. Information: P.A. Moore, UCSD Extension, X-001, La Jolla, CA 92093.

Managing Employee Assistance Programs July 10-11, Center City, Minnesota. Information: Linda Hutchinson, Hazelden, Box 11, Pleasant Valley Rd, Center City, MN 55012.

3rd Annual Chemical Dependency and Family Intimacy Summer Institute — July 14-19, Marine-on-St Croix, Minnesota. Information: Diane Campbell, Program in Human Sexuality, 2630 University Ave SE, University of Minnesota, Minneapolis, MN 55414.

Developing Employee Assistance Programs — July 24-26, Seattle, Washington. Information: Linda Hutchinson, Hazelden, Box 11, Pleasant Valley Rd, Center City, MN 55012.

Chemical Dependency and the Older Adult: Challenge of the 90s — Aug 1-2, St Paul, Minnesota. Information: Hazelden, Box 11, Pleasant Valley Rd, Center City, MN 55012.

36th annual conference of the Alcohol and Drug Problems Association of North America — Confronting the Issues — Challenges for the 80s — Aug-18-21, Washington, DC. Information: Eric Scharf, ADPA, 444 N Capitol St, Ste 181, Washington, DC 20001.

North American Congress on Employee Assistance Programs — Aug 26-30, St Louis, Missouri. Information: Diane Vella, congress coordinator, NAC/EAP, 2145 Crooks Rd, Ste 103, Troy, Michigan, 48084.

9th World Conference of Therapeutic Communities — Sept 1-6, San Francisco, California. Information: Walden House Inc, 815 Buena Vista W, San Francisco, CA 94177.

Adolescent and Family Treatment: An Investment for the Future — Sept 18-20, San Diego, California. Information: Nomi Feldman, conference coordinator, 370 Tansy, San Diego, CA 92121.

1st National Association of Lesbian and Gay Alcoholism Professionals Conference — Sept 26-29, Chicago, Illinois. Information: NALGAP, 1208 East State Blvd, Fort Wayne, Indiana 46805.

International Youth Services Conference — Oct 6-9, Chicago, Illinois. Information: Bill Treanor, executive director, American Youth Work Center, 1346 Connecticut Avenue NW, Ste 925, Washington, DC 20036.

Clinical Dilemmas in a Period of Change — Oct 9, Boston, Massachusetts. Information: Elizabeth Chichak, RN, New England Memorial Hospital, Five Woodland Rd, Stoneham, MA 02180.

National Federation of Parents for Drug-Free Youth, 4th annual conference — Nov 6-9, Washington, DC. Information: Mary Jo Green, NFP, 1820 Franwall Ave, Ste 16, Silver Spring, Maryland 20902.

Association of Labor Management Administrators and Consultants on Alcoholism, 14th Annual Conference — Nov 10-14, Boston, Massachusetts. Information: Judith Evans, associate director, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

Association for Medical Education and Research in Substance Abuse, 9th Annual Conference — Nov 14-15, Washington, DC. Information: Dr G. Lewis, AMERSA president, Center for Alcohol Studies, Brown University, Box G, Providence, Rhode Island 02912.

10th Annual Southeastern Conference of Alcohol and Drug Abuse (SECAD 10) — Dec 4-8, Atlanta, Georgia. Information: Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, GA 30342.

Abroad

International Youth Forum on Alcohol and Drugs — July 9-12, Cardiff, United Kingdom. Information: Dr Myrddin Evans, Addiction Unit, South Glamorgan Health Authority, Whitchurch Hospital, Whitchurch, Cardiff, CF4 7XB, United Kingdom.

1985 World Congress on Mental Health — July 14-19, Brighton, England. Information: Barbara Poole, world congress organizer, 22 Harley St, London, England W1N 2ED.

15th Biennial Caribbean Federation For Mental Health Conference — July 21-26, New Providence, Bahamas. Information: The Bahamas Mental Health Association, PO Box N-7531, Nassau, Bahamas.

3rd International Conference on Alcohol and Drug Abuse — Aug 11-14, Lima, Peru. Information: L. Vasquez, MD, International Education, Peruvian College of Physicians, Wadsworth, IL 60083.

2nd National Drug Institute — Alcohol and Drug Use in a Changing Society — Aug 14-16, Darwin, Northern Territory, Australia. Information: Chairman, NDI Planning Committee, Drug and Alcohol Bureau, Northern Territory department of health, GPO Box 1701, Darwin NT 5794 Australia.

12th World Conference on Health Education — Sept 1-6, Dublin, Ireland. Information: Mary D'Ardis, conference coordinator, 12th World Conference on Health Education, 34 Upper Mount St, Dublin 2, Ireland.

Seminar on Addiction/2 — Sept 5-15, Madrid, Cordoba, Seville, Marbella, Costa Del Sol, Spain. Information: Millglen Medical Corporation, PO Box 888673, Atlanta, GA 30356.

European Congress on Prevention of Alcoholism and Other Drug Dependencies — Sept 30-Oct 4, Opatija, Yugoslavia. Information: International Commission for the Prevention of Alcoholism and Drug Dependencies, Non-governmental Organization of the United Nations, 6330 Laurel St, NW, Washington, DC 20012.

International Congress on Local Authorities and Drug Policy — Oct 23-24, The Hague, The Netherlands. Information: Municipality of The Hague, Dr N. G. Geerts, MWV, PO Box 80.000, 2508 GA The Hague, The Netherlands.

1st World Congress on Drugs and Alcohol — Dec 15-19, Tel Aviv, Israel. Information: Congress Secretariat, Peltours Ltd, congress department, PO Box 394, Tel Aviv 61003, Israel.

10th International Congress, World Confederation for Physical Therapy — May 10-22, 1987, Sydney, Australia. Information: The Secretariat, 10th International Congress of WCPT, Australian Physiotherapy Association, PO Box 225, St Leonards, NSW 2064, Australia.

Parents must advertise this message, says US official

Grower to user, the drug chain imprisons

*More than 8,000 parent's groups in the United States have helped legislators set the tone for drug policy in that country today: any illicit drug use is unacceptable. Jon R. Thomas (left), US Assistant Secretary of State, told delegates at the PRIDE conference in Atlanta (see pages 1 and 3) that US substance abusers are victims at the end of an international grower-to-user chain which imprisons everyone. **The Journal** presents Mr Thomas' remarks below in synopsized form.*

Stockbrokers: when cocaine becomes an 'arm of struggle against US imperialism'

ATLANTA — There are few issues facing the United States, and the world today, as potentially devastating as the issue of narcotics abuse and trafficking. The attendant violence, corruption, terrorism, and destruction of social values which accompany the drug trade affect virtually all nations, all social classes, and all age groups.

A recent United Nation's (UN) report states that the illicit drug trade threatens the very stability of some governments. We do not have to look far to see that this threat is very real, very dangerous, and very immediate.

The drug-producing nations of Latin America are beset with violence and corruption as traffickers prey on innocent people, attempt to secure influence in their communities, and buy a voice in their governments.

In nations such as Italy, where leaders are taking courageous steps to prosecute narcotics traffickers, judges have become the target of terrorist attacks. Tragically, innocent bystanders have been killed as the attackers narrow in on their targets. Bystanders in Italy, Colombia, and Mexico have become the latest victims in the drug war.

But when we talk about victims in the war on drugs, we are not simply talking about an overdose victim whose brief life was ended by a batch of too-potent heroin. We are talking about each and every one of us who pays more in taxes because of the high price of enforcement, who worries about our children's futures, and who may, one day, be the victim of a drug-related crime.

We have heard the phrase "grower-to-user chain" used to describe the intricate network that links producers and consumers of narcotics. This chain now spans all continents, and the traditional producer nations have now become consumer nations because of the overflow of narcotics into their own societies.

Chains do many things: they link together; they bond; they imprison. And, those people on the opposite ends of the grower-to-user chain are shackled together in misery — in the miserable conditions which characterize producers, and in the miserable condition of the addict.

Meese

US Attorney-General Ed Meese, in a speech to the Washington Press Club on March 20, told his audience that no longer will the US tolerate a passive approach to drug use. For too long, particularly during the 1970s, drug use was considered "a victimless crime" with the user, supposedly, assuming full responsibility for his or her choice to use drugs.

However, it is clear that drug use is not a victimless crime: there are no passive users. The Attorney-General stated that drug users are not "just buying pleasure for themselves but . . . are supporting those who are dealing in terror, torture, and death."

Parents and representatives of all communities must advertise this message to young people around the world.

To the college student who is a casual user of marijuana, to the $60,000-a-year stockbroker who snorts cocaine on weekends, to the hardened heroin user who shoots up several times a day, we must say that they are not acting in a vaccuum, but are inextricable components of the grower-to-user chain. We must let them know that for every marijuana joint smoked, for every kilogram of cocaine snorted, or heroin injected, the life of a judge, an agent, an innocent bystander, is hanging in the balance. The user of narcotics — however casual the use — is responsible for the lives and deaths of those who are enforcing prohibitions against drugs.

Both ends of the grower-to-user chain are people who are equally abject, equally exploited. The Hill Tribesman who has cultivated the opium poppy for decades, selling the opium gum to the middleman, does not know of the heroin addict who steals to support his habit in Harlem, or Washington DC, Rome, or Karachi.

The tribesman, who receives little by way of a livelihood from opium sales, lives in poverty in remote villages in Thailand and Burma. For him, the term Golden Triangle used to describe the opium-producing nations of Burma, Laos, and Thailand is a bitter irony. Many believe that this area should be called The Triangle of the Pauper. He does not know that the profits from the raw opium that he has sold is funding an insurgency along the Thai-Burmese border, and that the opium is being converted into heroin in well-protected refineries. Neither he nor the user knows that countless members of the Burmese Army, the Burmese Police, and other organizations have been killed by the insurgents and the traffickers as the heroin makes its way out of the Golden Triangle.

The marijuana user who says that his action is a harmless form of recreation might consider the Attorney General's comments to be an overdramatization of the issue, another in a series of scare tactics.

Let us look at the facts. The marijuana smoked in the US comes, most probably, from Colombia or Mexico. It is doubtful that the marijuana smoker knows under what conditions the Mexican marijuana was grown — does he know of the slave labor conditions that were discovered when the marijuana plantation at Chihuahua, Mexico was raided? Does the user know that young children were promised decent wages by the traffickers if they came to Chihuahua to harvest the marijuana? These children were forced to work inhuman hours with little or no food, and were unable to escape from the plantation.

And, it is doubtful that the marijuana user knows that every time he buys another nickle bag of marijuana he is lining the packets of Caro Quintero of Mexico. His wealth is estimated at many millions of dollars, and he is accused of involvement in the death of US Drug Enforcement Administration agent Camarena in Mexico earlier this year.

Caro Quintero has admitted that his massive marijuana operation involved thousands of people, and that he was the principal owner of the 8,000 tons of marijuana seized during the Chihuahua raid last November. This man, who brandishes an AK-47 automatic rifle, who lives in palatial conditions, and until now, flaunted his outlaw status, is living off our children. His cocaine habit is being financed by US citizens who believe that their use of marijuana is "harmless." The death of agent Camarena removes beyond doubt this idea of harmlessness.

The peasant in Peru, who is being harrassed by traffickers and whose family is being threatened by terrorists, is part of the cocaine chain which is now enslaving more than one-million US citizens. The *campesino's* conditions have not improved because of the massive cocaine industry: the peasants do not own stock in the traffickers' phenomenal wealth.

The Wall Street stockbroker who began using cocaine recreationally, now finds that the $5,000-a-month habit has cost him his home, his job, and his marriage. But, his habit has allowed a trafficker like Carlos Lehder to buy a disco, another jet, and another newspaper. While the stockbroker is imprisoned in his addiction, Carlos Lehder is giving interviews to the press, calling cocaine and marijuana "an arm of struggle against American imperialism." Did the stockbroker willingly consent to this political struggle when he began his cocaine use? Few cocaine users understand that they are links in a chain, not only of imprisonment, but also of terrorism and insurgency.

Bonilla

In the past year, we have seen the assassination of Colombia's Minister of Justice, Lara Bonilla, the massacre of 19 Peruvian cocaine eradication workers, the kidnapping and murder of US and foreign enforcement officers. These are the violent episodes which indicate to the world how serious the traffickers are in protecting their interests. However, it is now obvious that we are equally serious in protecting our interests and the interests of democracy as we pursue the traffickers internationally and work to separate them from their assets and the source of their livelihood.

In a September, 1984 speech, US Secretary of State George Schultz warned that the lawlessness associated with narcotics trafficking is posing grave threats to the security of societies and institutions. He stated that narcotics traffickers are the modern-day version of pirates, and stressed the need for an immediate, international response to the danger that all of us face as a result of trafficking and abuse. As the world once brought together its combined efforts to defeat piracy and slavery, so must we marshall our forces against this modern day piracy and slavery.

No one country can face these traffickers alone, and no one country should have to. Nations must work together as an international community to ensure that there are no safehavens for narcotics traffickers — nowhere for them to hide from the law, nowhere for them to launder their money, and nowhere for them to invest their profits. In this international effort there can be no passive nations — and those nations that provide protection of any kind to these criminals should be considered by the rest as collaborators in this crime against world morality.

We have already begun to see the results of international cooperation in the fight against narcotics trafficking; most recent was the tremendous cooperation among Costa Rica, Mexico, and the US to apprehend Caro Quintero. We were encouraged by Colombia's extradition of four traffickers to the US, and by the promise of future extraditions. We are encouraged that improvements are being made in international banking and financial regulations in an effort to halt the practice of money laundering and to make financial information available in investigations of traffickers.

The international community is prepared to deal with traffickers. They will be hunted down, extradited, prosecuted, and jailed. The day of free rein for the narcotrafficker must end, and must end now.

As enforcement efforts increase, so must our efforts to control narcotics production and use. The Bureau of International Narcotics Matters, the department of state, will continue working with nations such as Colombia, Peru, Pakistan, Mexico, and Thailand to eradicate coca, marijuana, and opium plants. Through manual and aerial eradiction, nations have been able to illustrate the extent of their commitment to crop control. Pakistan and Thailand have taken significant steps in controlling opium production in areas which have, in the past, presented special difficulties. Farmers in those nations are beginning to understand that the cultivation of opium is against the law, and they are being presented with options for maintaining adequate income through the transition from illegal to legal crops.

We are working also actively with the European nations that are experiencing an increase in heroin use and are on the threshold of a cocaine epidemic. The tragic new levels of drug use by Latin American and Asian youth demand immediate action. No longer is the narcotics problems 'an American issue' which requires an American solution.

The year 1985 promises to be a landmark for narcotics control. Already, we have seen the historic convening of First Ladies from around the world who are committed to solving our drug problems. We have seen renewed vigor in narcotics campaigns in nations such as Mexico after the realization that narcotics trafficking and abuse are serious national security problems. And, we have seen our own nation heed the call to arms against drug trafficking and abuse with the establishment of more than 8,000 parents groups across the nation.

In closing, let me share with you something disturbing I came across on a recent trip to Malaysia. In a teenage girls' magazine, a young Malaysian student writes about her experiences as a student in the US. One of the most difficult adjustments she is expected to make is in the area of alcohol and other drug use. She writes: (the American students) "are 18 and they've got serious drinking problems. High school kids smoke pot before school starts. I've seen it on the roadside on the way to class. And, college students do cocaine in their cars between classes."

Is this the image of American students that we want portrayed to the rest of the world? I know that it is not. However, we must make sure that such a perception is not a reality by getting the message across that narcotics is a dangerous activity, and that the user is responsible not only for himself, but for all of those involved in the narcotics business. From grower to user, the chain imprisons. And, on one end of that chain is a young person who could not say 'no.'

THE BACK PAGE

Canadian parents joining forces?

By Elda Hauschildt

SASKATOON — A Saskatchewan-based national parent group against drugs considers it is on the threshold of developing a Canada-wide movement, after 550 delegates oversubscribed its first conference here.

PRIDE CANADA (Parents' Resource Institute for Drug Education, Canada), which is affiliated with PRIDE-Atlanta, had 350 adults and 200 youths at its recent three-day conference at the University of Saskatchewan. A month earlier (**The Journal**, June) only 140 people had pre-registered.

Based on the conference turnout, PRIDE now expects the Canadian movement to take off.

Opheim

"If it happens like it did in PRIDE Atlanta, it'll happen fast," Eloise Opheim, PRIDE Canada president told **The Journal** at the meeting here.

"We've been thinking about how do we build — do we build really, really slowly and very cautiously, as we must do? At the same time, we have to be prepared for the mushroom that is going to happen. We have to be prepared in terms of human resources, in terms of printed materials, in terms of money."

PRIDE-Atlanta registered 175 for its first national conference in 1978. Now there are between 8,000 and 9,000 parent groups in the United States, and more than 3,000 people attended PRIDE's May conference in Atlanta (**The Journal**, June).

"But what happens with us is that we don't have those first three

(See **Parent — p6**)

Vol. 14 No. 7 2nd Class Mail Reg No. 2776 TORONTO July 1, 1985

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Pope John Paul II and ICAA President David Archibald in Rome: 'in the name of fundamental human solidarity'

Pope John Paul II addresses ICAA

ROME — The role of the family is elemental in the potential abuse of alcohol by young people, Pope John Paul II told an international conference on the prevention and treatment of alcoholism here.

"It is the family which most powerfully influences young people in the area of alcohol," the pontiff said.

"The example given by parents in all things, including the abuse of alcohol, is foremost in the formation of the young. The child is watchful and alert in observing how the father and mother cope with the pressures of life. The child can be easily led to imitate behavior patterns which have been learned at home.

The Pope addressed the 31st International Institute for the Prevention and Treatment of Alcoholism, sponsored by the International Council on Alcohol and Addictions.

Alcohol abuse by the young is "particularly worrisome," he added.

"Many factors come into play in this social evil, not the least of which are peer pressures and group involvement in surroundings which are unwholesome and which prevent young people from maturing and becoming happy and healthy human beings.

"Likewise, the economic conditions existing in society, such as the high rates of poverty and unemployment, can contribute to a young person's sense of restlessness, insecurity, frustration, and social alienation, and can draw that person to the fantasy world of alcohol as an escape from the problems of life."

The Pope offered "my encouragement to all who work toward a solution" to the alcohol abuse problem.

"In particular, I would like to thank all those who, in the name of fundamental human solidarity, strive to assist people who suffer from alcoholism," he said, including individuals and institutions providing "an invaluable service."

UN chief wants top-level action by 1987

Global drug meet urged

By Anne MacLennan

UNITED NATIONS, NY — The secretary-general of the United Nations has called on countries around the world to show they are committed at senior levels of government to reducing drug abuse and trafficking.

Javier Perez de Cuellar wants a multi-disciplinary, international conference on drugs in 1987. And, he wants participants of ministerial-level authority.

He made his call for the meeting through one of the most senior political and legislative bodies of the UN — the Economic and Social Council (ECOSOC), which acts directly under the General Assembly and oversees world drug control through its Commission on Narcotic Drugs (CND) and the International Narcotics Control Board.

It is believed this is the first time a secretary-general has taken an advocacy role in drug issues. It's now up to governments to respond.

One of Canada's senior statesmen in UN drug affairs is Donald Smith, PhD, senior scientific advisor, intergovernmental and international affairs, Health and Welfare. He is also a former chairman of the CND, and one of its leading and most experienced voices.

He told **The Journal**: "This is a very major initiative in this field. Now, we'll have to see if it gets off the ground. Governments are now going to have to decide whether to say yes."

Making the decision, preparing country positions, and translating it all into action — if the conference is to take place — will involve thousands of bureauerats and experts around the world. But, the fact the secretary-general himself called for the meeting is seen as a good indication it will go ahead.

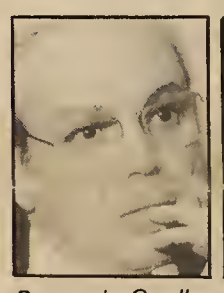
In Canada, the decision and the tack Canada takes rest ultimately with Secretary of State for External Affairs Joe Clark, acting on advice from officials of his own department, with input from federal justice, health, and enforcement experts, among others.

See UN chief — p9

Terry Sheehan is director general of the external affairs department's immigration and social affairs bureau. The bureau is involved in a wide range of social issues addressed by the UN, including drugs.

He told **The Journal** the statement is "interesting," and reflects increasing attention to drug issues at the UN. He referred particularly to the General Assembly's interest in a new and tougher international convention aimed at

(See **Clark's — p2**)



Perez de Cuellar

Smith

Canada's role in Nairobi — p3

British MPs order all-out drug war

By Alan Massam

LONDON — An all-party committee of members of parliament has finally kindled public alarm about the growth of hard drug abuse in Britain.

They have called for draconian powers to deal with the problem, including confiscation of all the assets of drug traffickers — with the onus of proof resting on the accused.

The 11-strong committee also wants to see army, navy, and air force units used to trace and block drug supply routes; intensified action by customs officials; harsher penalties for drug offences; and reform of banking laws which currently allow drug barons to launder their profits.

And, they insist marijuana should remain illegal because experimentation with it can "lead on to the use of hard drugs."

The committee, under Sir Edward Gardner, produced the report after visiting North America and finding out first-hand the extent of cocaine abuse.

"We believe, from all we saw and heard, that as the United States market becomes saturated, the flood of hard drugs will cross the Atlantic," they say.

"We fear that unless effective and immediate action is taken, Britian and Europe stand to inherit the US drug problem in less than five years.

"Western society is faced with a war-like threat from the drug industry. The traffickers in hard drugs can amass princely incomes from the exploitation of human weakness, boredom, and misery.

"The war has never been openly declared, and the drug traffic has infiltrated insidiously into the West."

The MPs added that they felt it "frightening" that the richest country in the world could do noth-

(See **Drug — p2**)

INSIDE

NEWS

Briefly...

A burning issue

LONDON — The health of non-smokers may be more at risk from carbon monoxide fumes gathered by home-heating appliances than from cigarette smoke, says a report in *Doctor*. Researchers report that slow-burning coal or wood fires, coal or wood stoves, and paraffin heaters are a dangerous source of poisonous CO. In homes with heavy smokers, however, and central heating or electric fires, CO measurements are substantially lower.

Drug trial ethics

LONDON — Volunteers in drug trials should be more carefully screened before being allowed to take part. And, their general practitioners should be contacted for information as they already have comprehensive medical data on the individual, says a report in *Medical News*. The Royal College of Physicians here may recommend that payments to volunteers be limited to £100 (Cdn$175), because anything more than this could be considered an inducement. The college is preparing the report following the deaths, last year, of two volunteers.

Against their will?

WASHINGTON — The United States National Organization for the Reform of Marijuana Laws (NORML), charges that President Ronald Reagan's war on drugs is causing a new form of child abuse. The NORML claims that in the last four years there has been a 350% increase in adolescent admissions to psychiatric hospitals related to "forced confinement for unnecessary" drug treatment. "The Reagan Administration is directly responsible for these abuses. They are funding extreme anti-marijuana parent groups, and appointing people to government positions who approve of these tactics," says Kevin Zeese, national director.

Alcohol on the water

WASHINGTON — A national attempt to get United States recreational boaters to stop drinking and cruising is paying off, says US Secretary of Transportation Elizabeth Dole in *The Alcoholism Report*. "Greater public awareness of the dangers of alcohol and boating, and stricter enforcement by some states, is helping save lives," she said of the National Recreational Boating Safety Program. Boating deaths in 1984 were the lowest since 1961 with a fatality rate of 6.8 per 100,000 estimated boats, a 14% decline since 1983.

Alcohol's price tag

ST JOHN'S, Nfld — Alcohol abuse costs every man, woman, and child in this island province $100 a year, says a report in *The Medical Post*. Total costs found to be associated with, or attributable to alcohol abuse in 1982/83 were found to be $56 million. The Alcohol and Drug Dependency Commission here estimates the health care portion of the costs to be $25 million. Other costs attributed to alcohol abuse were those to the criminal justice, social services, and fire departments, and prevention and rehabilitation.

Inflation squeezing US research

By Elda Hauschildt

SASKATOON — More funds are being funnelled into alcohol, other drugs, and mental health research in the United States every year, but the inflationary cost of the research itself offsets each increase.

"There are more dollars, but we really are pinched by the inflation within research grants," Ian Macdonald, MD, director of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), told **The Journal** here.

"Our 1985 budget had a built-in 4.2% increase in agency monies across the board — alcohol, drugs, and mental health," Dr Macdonald explained.

"But the rate of inflation for the grants people talk most about (investigator-initiated awards) has been an average of 8.5% over the last 15 to 20 years. It was 8.3% in 1985.

"So, you are stuck with a 4.2% increase in dollars, and a 8.3% inflationary increase.

"Times are pinched. There's no question about that. But, the opportunities are better than they ever have been. It's a painful time to exist in research," he said.

PRIDE CANADA stories —p6

The ADAMHA's 1985 fiscal budget was close to $1 billion, divided almost equally between research ($440 million) and service ($490 million). It is the umbrella organization for the US national institutes on: alcohol abuse and alcoholism (NIAAA), drug abuse (NIDA), and mental health (NIMH).

Each of the three agencies spends 80% of its budget on research, and 40% of that research money is for intramural research programs.

Dr Macdonald said the 8.5% inflation rate within grant requests presented to the ADAMHA —which funds approximately 500 requests annually — can no longer be put down to general inflation.

"You could understand an 8.5% increase within grants back in the 1970s when our national inflation rate was up in the teens. But why is it still up there? I don't know all the answers," he said.

One answer may be in the research now being done, he said.

"With the explosion within science, it gets more expensive. You can't do the same things as you used to, because you can do better.

"To put it another way, it's not surprising that the grants are more expensive because we really have Cadillacs where we used to have Chevrolets."

Dr Macdonald, who was in Saskatoon to address the first national conference of PRIDE CANADA (Parents' Resource Institute for Drug Education, Canada), said the ADAMHA is working under a "Congressional mandate" to fund prevention research, as well.

"What we are learning is that prevention research is more expensive than other research, because it is labor-intensive," he added.

Macdonald: more dollars

Enforcement 'supports drug prices'

By Lynn Payer

UNITED NATIONS, NY —Current drug enforcement programs are simply a price support program for heroin; only a reduction in the demand for drugs can have any long-term effect, a UN narcotics and substance abuse committee has been told.

David Feingold, director of the Center for Opium Research in Philadelphia, said enforcement agencies have for years used the "magic 10% figure" for the amount of drugs they were stopping from coming out of the fields.

"Let's take that figure and ask what it means. It means we're spending more and more money to guarantee that 90% gets through," he told the non-governmental organizations (NGO) committee meeting here.

"There is so much opium produced in the world that, quite honestly, if you did away with all the opium in Thailand and all the opium in Burma — which is not going to happen in our lifetime — it would still not have a significant effect on what is going on in New York City."

The committee, made up of observers from NGOs concerned with drug abuse prevention, is one of two formed in the last two years — the first at UN headquarters, Vienna, where the Division of Narcotic Drugs is based, and the second at UN headquarters, New York (**The Journal**, June).

As an anthropologist who worked among opium growers and traders for 20 years, he said he knows opium is not a lucrative crop for farmers. It takes 367 man-hours to produce a kilo-and-a-half of opium, so, a household gets about $50 for a year of labor.

Farmers produce opium, Mr Feingold explained, because it has a high value per weight.

"If you live up in the jungle, your transport costs are terribly high, and it costs you a lot to get your crop to market."

Opium is also used medically and for recreation.

Most importantly, opium is the equivalent of American Express traveller's cheques in large areas of Thailand, Burma, and Laos. It is one of the few consumable currencies used throughout the world, like coca in Peru, salt in New Guinea, and dried fish in 15th Century Iceland.

Consumable currencies are buffered against substantial inflation because of their expendable-use value and a semi-permanent exchange value within a local system. The drug can easily be traded in the exact amount needed, he said, and is more acceptable over a wide area of the hills than Thai, Burmese, or Laos money.

It is also less susceptible to devaluation. It has little weight per unit of value; is almost infinitely divisible; and, under the proper conditions, probably does not deteriorate significantly after the first month of storage.

"One of the dangers of the emphasis on mafias and nasty people doing nasty things is that it removes our attention from the economic and social realities that underlie the problems," Mr Feingold said.

In the United States, he said, "Nancy Reagan, (wife of US President Ronald Reagan), meets the other 'first ladies. They get together and say 'drug abuse is nasty.'

"Then look at what her husband did to treatment budgets in this country, and you'd find that even if enforcement worked, which it won't, it would force more junkies into treatment, and we wouldn't have the treatment slots to treat them."

. . . reduction of demand is key

UNITED NATIONS, NY — Success or failure in the fight against drugs may depend on whether "we gain the minds of the people to our side," says Francisco Ramos-Galino, deputy director of the United Nations Division of Narcotic Drugs.

"If the mafia cannot sell their drugs, they will be out of business," he told a meeting here of the UN non-governmental organizations (NGO) committee on narcotics and substance abuse.

Mr Ramos-Galino agreed with another speaker, David Feingold, that the fight against drugs must focus on reducing demand, because the supply is simply too great.

Ramos-Galino

If the supply of cocaine in Bolivia, for example, is translated into New York city street prices, the result is a figure four to five times greater than Bolivia's gross national product.

"It is very difficult for national governments and also for the international organizations to try to contain illicit traffic.

He said people must be convinced that drug trafficking in any form is despicable. While many people have "bleeding hearts" for the small traffickers, said Mr Ramos-Galino, "to me a small trafficker is a small trafficker because he cannot be a big trafficker."

Clark's UN conference decision pending

(from page 1)

drug traffickers (**The Journal**, April).

However, he said it was still too early to comment on the department's likely position on the conference. "This whole question cuts across a number of departments, including justice and the RCMP" (Royal Canadian Mounted Police) and others, and there will be many discussions before a decision is made, he said.

Whose advice carries most weight with Mr Clark remains to be seen.

Traditionally, health experts have played a major role in formulating Canada's stance. However, observers say health and enforcement people are increasingly being relied on for "technical information" only, as external affairs officials move into a leadership role.

An illustration came at the February meeting in Vienna of the CND, when, for the first time, a Canadian ambassador (to Austria and the UN there) went well beyond being nominal head of the Canadian delegation. Ambassador Alan Sullivan spoke repeatedly for the Canadian team.

Some observers suggest increased involvement by external affairs has, for example, potential for diminished Canadian emphasis on health concerns in international drug affairs, and perhaps for increased attentiveness to international politics.

Too, an evolving role in drug affairs for the department means an evolving department bureaucracy facing a new, to them, vocabulary.

Drug dealers must 'lose all'

(from page 1)

ing more than hold the line against drug abuse. They said dealers should be treated as mass murderers and sentenced to life imprisonment.

Their report adds:

"Drug dealers must be made to lose everything — their homes, their money, and all that they possess which can be attributed to profits from selling drugs.

"The ruthlessness of drug dealers must be met by equally ruthless penalties once they are caught, tried and convicted."

The MPs add that no dealer should be prepared to risk entering the UK market because of the size of the punishment likely to be imposed.

At a press conference after publication of the MPs' report, a spokesman said that possibilities of international cooperation to crack down on drug abuse had already been discussed.

NEWS

UN Decade for Women conference

Canada to take leadership role in Nairobi

Joan Hollobon reports

TORONTO — Canada has been invited to chair the Western group at the United Nations conference ending its Decade for Women being held this month in Nairobi.

Walter McLean, secretary of state for Canada, leader of the official Canadian delegation to the Kenya conference, told **The Journal** this "is an indication of the sense of leadership we have been giving."

Health issues, including abuse of alcohol, prescribed and illicit drugs, and the increasing use of tobacco by women, including pregnant women, are high on the list of concerns.

There are two overlapping conferences: the governmental conference, July 15 to 26, and the Non-Governmental Organizations (NGO) forum, July 10 to 15. At least 200 Canadians representing some 40 groups were scheduled to attend the NGO forum in addition to Canada's large official delegation to the governmental conference (**The Journal**, June).

Mr McLean said from Ottawa that "even if the conference were cancelled tomorrow, the effort would have been worthwhile, because in the process of preparing to go, people start to look at what they've done."

Mr McLean said the significance of the 10-year focus on women's issues, such as health, education, "and the opportunity to be treated equally" is that in every participating country, including Canada, "it has thrown a signal into the bureaucracy" that these issues are important.

In Canada, this has resulted in the past few years in a number of meetings, studies, and reports.

For example, a seminar on Women in Health and Development in Ottawa two years ago, sponsored by Health and Welfare Canada's senior adviser on the status of women, was told that "the main issues confronting women at present concern addictions," defined as problems with alcohol, prescription and non-prescription drugs, and tobacco.

Also in 1983, a report of the Task Force on Reproductive Health described the seriousness of smoking and drug use during pregnancy. It noted, among other things, that babies born to smokers are smaller, and that heart attacks among women of reproductive age are two to four times more likely to occur among smokers than non-smokers.

Mr McLean said Canada took an active part in 1975 at the UN conference in Mexico City to open the decade, and also took "a tremendous part" in preparation for the mid-decade 1980 Copenhagen conference.

He attended that conference as critic for women's issues when the Progressive Conservative party was in opposition prior to change of government last September. On his appointment as secretary of state with responsibility for status of women, he moved quickly to meet provincial counterparts. A similar meeting recently, prior to the first ministers meeting, coincided with preparation for the Nairobi conference. Provincial ministers and officials will be part of the Canadian delegation, because "whether it's employment, health, or education issues, almost none of them are things the federal government can deal with exclusively," he said.

Although much remains to be done in this country, Mr McLean considers Canada has "a reason and a right to exercise a moral leadership, and I believe the women's movement in Canada expects us to do that. It is consistent with the sort of moral leadership that Canada seeks to give in terms of finding non-military solutions in the world; in finding ways of enhancing development assistance, and in trying to encourage the voluntary sector and people-to-people contact."

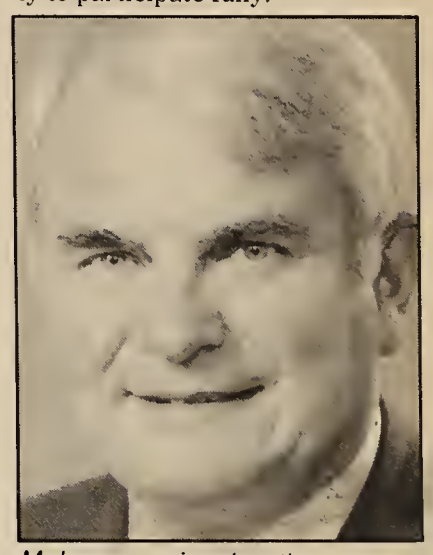
He said that the Copenhagen conference particularly "showed where Canada was, showed what needed to be done . . ."

For example, he attributed part of the impetus to amending the Indian Act (which deprives Indian women married to non-Indians and their children of their Indian status) to the UN Decade. Bill C31 to amend the Act was passed by the House of Commons and sent to the Senate in June.

Peace and development, two of the stated themes of the conference, are Canadian foreign affairs concerns, as well as women's issues, but many others are "bread and butter issues."

Mr McLean said he looks forward most to the NGO forum. At the government level, diplomats often try to "get above" the concrete concerns, but at the NGO, "you have got a larger group of people who are there because of their commitment . . . the growing women's global network.

"There you have people sharing their experiences in the struggle for equality, saying what they have to do to lobby their way into legislation — health care, education, nutrition — whatever the issues are that attacked women's capacity to participate fully."



McLean: signal thrown to bureaucrats across the world to wake up to women's issues

Concurrent agendas could confuse

TORONTO — Risks and tensions exist in holding a United Nations meeting and the Non-Governmental Organizations (NGO) forum concurrently in Nairobi, Walter McLean, Canada's secretary of state, told The Journal.

Some of those who attended earlier Decade of Woman conferences at Mexico City and Copenhagen were "profoundly disappointed," as they moved from one conference to the other.

At the NGO forum all participants are deeply committed to women's issues; at the UN conference, the discussion may suddenly get sidetracked into, say, Arab-Israeli conflicts or South African apartheid, or a whole range of issues that have no direct relevance, but which reflect the interests and prejudices of various governmental delegations.

"You see this all the time at Geneva or New York City or wherever the UN meets," said Mr McLean. The Canadian delegation therefore must have a "unique mix," including technical experts on how the UN operates and why delegations take the positions they do.

Unless those who move back and forth between the two conferences understand the differences, they may be disappointed and also lose sight of the real importance the UN Decade for Women conferences have had on the nearly 160 participating countries.

A major expenditure of "emotional and mental energy" has taken place around the world as each country strives to explain its position. Even the process of "preparing those pounds of documentation . . . means you have turned the public service to look at women," he said.

Canadian tobacco agency unnecessary: CMA

By Joan Hollobon

TORONTO — Canada does not need a tobacco marketing agency, the Canadian Medical Association (CMA) has told the National Farm Products Marketing Council.

Canadian tobacco growers have asked the marketing council to institute such an agency and requested that anti-smoking groups be excluded from hearings on the proposed agency. The marketing council ruled in May it would hear all interested parties submitting briefs, as the CMA has done.

The CMA's brief says it is "inconceivable to the medical profession" that the federal government could contemplate establishment of a tobacco marketing agency when the policies and anti-smoking programs of the Department of National Health and Welfare attest to the government's unequivocal recognition of the relationship between smoking and health problems.

"If, as has been stated, one of the objectives of the proposed Tobacco Marketing Agency is to have due regard to the interests of producers and *consumers* of tobacco, it would direct its efforts to self-destruction and/or attempts to find a less harmful crop for farmers to grow and market. Why form the agency in the first place?"

The CMA, representing 39,000 Canadian physicians, urged the marketing council to recommend to the minister of agriculture and the Canadian government that, instead of such an agency, "available energies and resources be used to develop alternative crop incentives for farmers and to provide interim transitional subsidies for farmers currently growing tobacco."

The marketing council has held public hearings in four centres in tobacco growing areas: London and Ottawa, Ontario; Charlottetown, Prince Edward Island, and Montreal, Quebec.

Harry Halliwell, director of economic advisory services to the council, told **The Journal** from Ottawa he hopes reports from these hearings will reach the full council within a few months.

The procedure then is for council to report to the minister of agriculture. If this report favors establishment of an ageney, the minister can (if he also favors the move) empower the council to initiate federal-provincial discussions with the tobacco growing provinces. If agreed at this stage, and if favored by a majority of tobacco growers in Canada, the proposal would go forward for Cabinet approval.

The CMA hrief said cigarette smoking is the leading cause of preventable death and disease in Canada, aecounting for some 30,000 deaths annually.

"Smoking-related diseases have heen so eostly in terms of premature death, lost productive life, and medical care, that in a hrief presented to the federal government (1969), the CMA placed the cessation of smoking at a level of importance in preventive medicine with pasteurization of milk, purification and chlorination of water, and immunization," the brief notes.

Smoking among physicians has dropped from about 60% to fewer than 14% today, but "I am ashamed the figurc is not 0%. . . .," CMA president T. Alex McPherson, MD, of Edmonton, told the marketing council. Dr. McPherson is an oncologist.

The CMA refuses tobacco advertising in its publications and refuses to invest in tobacco product stocks.

The brief also affirmed the CMA's interest in public and school educational programs; the protection of non-smokers against involuntary exposure to tobacco smoke; support for the World Health Organization's recommendations on reducing the size of tobaeco-growing and manufacturing industries and the export of tohacco products; and, the progressive reduction of tar, nieotine, and earbon monoxide yields from tobacco produets.

McPherson: ashamed of statistic

From the heart of the tobacco belt

Pro-smoking trustee raises CMA hackles

TORONTO — A school trustee in Ontario's tobacco growing country stirred up a storm recently when he said, "I don't believe one teenager has died from smoking."

Edgar Walcarius said he knows 19 year olds who smoke without showing ill effects; that he is far from convinced smoking causes cancer; and, that he believes concerns about the effects of smoking reflect "some kind of health kick they're on now."

Press reports of the remarks drew swift response from the Canadian Medical Association, whose president, T. Alex McPherson, MD, termed them harmful, ridiculous, and "totally inexcusable." (See related story.)

Mr Walcarius's comments were made during a discussion by the Elgin County Roman Catholic Separate School Board of a resolution against lifestyle advertising of tobacco. The Elgin County (Public) Board of Education had sent the resolution to the separate school board seeking its support for a petition to "the appropriate provincial and federal ministries requesting that lifestyle advertising of tobacco be eliminated."

The separate school board refused to support the resolution, which Mr Walcarius termed "silly . . . ridiculous, coming from the heart of the tobacco belt."

Dr McPherson, in a letter to the school hoard chairman Carolyn Elliott, said: "As a practising oncologist, I see the ravages of cancer caused directly by tobacco use every day. The decision by you and your fellow trustees to reject a resolution, the merits of which are grounded on overwhelming scientific evidence, is incomprehensible. As a physician and a parent, I urge you to reconsider."

Mrs Elliott told **The Journal** in a telephone interview from her home in St Thomas, Ontario, she did not personally cast a vote; as chairman, she votes only to hreak a tie. As a nurse, a non-smoker for 16 years, and a parent of three teenaged children, however, she is personally against smoking for health reasons.

However, she told **The Journal**, "I can't tell other people what to say."

She said nagging had achieved nothing with her husband, a smoker for 20 years. "So, my next approach is 'the insurance is paid up; who would you like to march your one-and-only-daughter down the aisle?' "

NEXT MONTH

A week in the life of the Alberta Alcoholism and Drug Abuse Commission

NEWS

RESEARCH UPDATE

Dangers of smokeless tobacco surface

Smokeless tobacco — in the form of chewing tobacco or snuff — has been shown in two different studies to be related to high-blood pressure in young adults, and to contain large amounts of sodium. Three researchers at Ohio State University included more than 100 current and former smokeless tobacco users in a study to screen for oral cancer and high blood pressure in a group of males more than 18 years old. The mean blood pressure of the 19 current, male, smokeless-tobacco users aged 18 to 25 years was 143.7/80.7 mm Hg, compared to 127.7/70.0 mm Hg for a group of male cigarette smokers of similar age. The researchers said that "along with the addictive characteristics of nicotine and its etiological role in cancer, smokeless-tobacco use appears to be associated with high blood pressure in young adults." They said this may hold true for younger age groups in which the consumption rate is increasing. The other study, by Neil Hampson, MD, of Duke University Medical Center, Durham, North Carolina, evaluated the sodium content of 16 retail brands of smokeless tobacco. He found the samples contained levels of salt comparable to those found in cured bacon and dill pickles, "which are traditionally considered extremely high in sodium." Dr Hampson said doctors should be aware smokeless tobacco might pose a potential threat to patients with restricted sodium intake.

The New England Journal of Medicine, April 4, 1985, v.312:919-920

In-hospital identification of heavy drinkers

Identifying and counselling heavy drinkers who are in hospital but not receiving treatment for alcoholism can be an effective intervention, according to researchers in Scotland. An initial group of 731 men between ages 18 and 65 admitted for at least 48 hours to one of a variety of medical wards at the Royal Infirmary, Scotland, were interviewed to identify problem drinkers. Of 161 patients identified, 78 were allocated to either a control group who received no additional treatment for their drinking, or a treatment group who were counselled by a nurse for up to one hour on the dangers of excessive alcohol consumption. Of the patients in the study, 133 were interviewed one year later and metabolic measurers of alcohol consumption were available for 124. The study found 64% of patients in the counselled group claimed they had reduced their alcohol consumption by at least 50%, compared with 48% of controls. Complete blood tests showed 52% of the treatment group were definitely improved as opposed to 34% of controls. Speculating that patients may be especially receptive to counselling while recovering from a medical illness, the researchers from the alcohol problems unit of the Royal Edinburgh Hospital, concluded that screening for alcohol problems should be a routine part of nursing assessment.

British Medical Journal, March 30, 1985, v.290:965-967

Static ataxia as genetic marker for alcoholism

Another study — this time of body sway in men — has advanced the search for a genetic marker of vulnerability to alcoholism by one more step. Marc Schuckit, MD, department of psychiatry, University of California, San Diego, followed up earlier studies from the centre which showed young men at high risk of alcoholism because of having an alcoholic close relative, had a decreased reaction to alcohol. In the current study, he compared the amount of body sway or static ataxia in 34 drinking but non-alcoholic men aged 21 to 25 years, who have an alcoholic first-degree relative, with 34 paired control subjects. Dr Schuckit found that following a 0.75 millilitre per kilogram dose of alcohol, the group with a positive family history of alcoholism had significantly less increase in body sway, with similar but less dramatic results following consumption of 1.1 mL/kg of alcohol. Along with earlier findings, he said, these results suggest a decreased intensity of reaction to ethanol may be a trait marker of vulnerability toward alcoholism. But, he cautioned, alcoholism is probably a "polygenic, multi-factorial disorder," and it is unlikely any one factor will explain the risk of alcoholism.

Archives of General Psychiatry, April 1985, v.42:375-379

Clonidine efficacy in opiate withdrawal

Clonidine appears to be a safe and efficacious drug for out-patient treatment for opiate withdrawal, and may have an advantage over methadone detoxification in this area. That is the conclusion of a study conducted at the Yale University medical school psychiatry department and the Connecticut Mental Health Center. Researchers reported on 49 methadone hydrochloride-maintained patients whose dose had been lowered to 20 milligrams daily. They were randomly assigned to either a group detoxified using methadone at 1-mg decrements daily, or a group abruptly switched to clonidine, who received daily doses of up to 1 mg of the drug. About 40% of both groups achieved successful detoxification, with one third of both groups remaining opiate free during the subsequent six months. While withdrawal symptoms were similar in both groups, the clonidine group experienced side effects and withdrawal symptoms in the first half of the 30-day study period. The methadone group only experienced symptoms when the dose began to drop below 5 mg per day. In addition, two clonidine subjects had to withdraw from the study because of the severe clonidine side effects, primarily sedation. Despite its lower rate of success when compared to in-patient studies, the researchers said clonidine might be superior to methadone on an out-patient basis. The drug is not a controlled substance and would be available to a wider range of doctors. And the minimum time required for successful detoxification is 10 to 13 days compared with 20 to 30 days for methadone.

Archives of General Psychiatry, April 1985, v.42:391-394

Pat Rich

BC physicians re-open debate on heroin use

WHITEHORSE — Physician debate on the issue of allowing heroin use for pain relief is far from settled, if the recent meeting here of the British Columbia Medical Association (BCMA) is any indication.

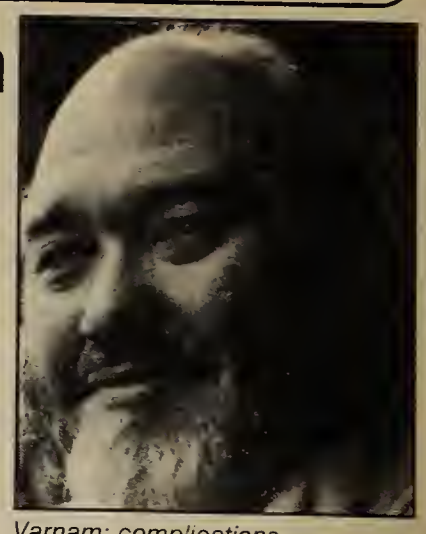
Despite the endorsement of such a move by the Canadian Medical Association (CMA) last fall (**The Journal**, October, 1984) the drug dependency committee of the BCMA introduced a resolution here to oppose lifting the ban on the drug.

Kenneth Varnam, a Vancouver MD, committee chairman, said the committee felt heroin should not be available for medical use because there is no evidence to prove it is a superior pain-relieving drug, and because it would complicate control of illegal use of the drug.

A physician remembers — p16

If heroin becomes available when the government works out a protocol to control its use, Dr Varnam said, "we are going to have increasing drug store break-ins, hospitals broken into, and we're going to have cancer institutes broken into."

BCMA president Gerry Stewart, MD, pointed out that the BCMA board of directors had pressed for legalization at the CMA meeting and would not likely support this resolution.



Varnam: complications

On his advice, the doctors adopted a second proposal from the committee calling for strong controls on prescription of heroin by the profession.

Alcoholism centre director suggests

Women do better in own setting

By Joan Hollobon

TORONTO — Women alcoholics benefit most from an all female program, says Jacqueline P. Ferguson, managing director of the Jean Tweed Treatment Centre here, which opened out-patient services for women late last year.

"Women are different — physically, mentally and hormonally," she said.

An in-patient program is scheduled to open in October when renovations are completed on Cumberland House on the site of a former psychiatric hospital here.

The centre accepts 12 women every 28 days for an intensive rehabilitation program from 9:30 am to 4 pm. The in-patient program will admit 15 women, also for a 28-day period.

Women will be considered for the in-patient program if they are too physically or mentally impaired or live too far away to get to the day care program.

Ms Ferguson, who has worked in all male settings too, told **The Journal** women often find it difficult to "open up" in mixed groups.

"In mixed groups, men tend to dominate, to take control. A housewife doesn't want to talk about the stress of running a house when executives are talking about the stress of running a major corporation," she said.

Also, women have physical and emotional problems they often will not discuss in front of men.

"Pre-menstrual syndrome, for example, varies from person to person, but many women alcoholics find they drink more then. Many also are more violent premenstrually," said Heleni Davison, the centre's corporate and community relations manager.

About 8% or 9% of women attending the centre are cross-addicted.

"A lot of women come in cross-addicted to Valium (diazepam). Or they may start off with cocaine and then move to alcohol," Ms Davison said.

Women are referred from social service agencies, through calls from concerned families and from corporations seeking help for employees. Some phone directly.

"Employers are becoming very understanding. They're finding too, that if they can get a good employee back, it's better than having to train a new person," Ms Davison said.

Davison

Ferguson

The 50 women treated so far have included housewives, career women, rich and poor, from 16 to 70 years old.

Women who require detoxification on arrival are sent to the Addiction Research Foundation's Clinical Institute here, which refers them back after treatment.

A mental, emotional, and physical assessment, including a medical examination, occupies the first two or three days after admission.

"A woman in terrible shape physically, perhaps with liver damage, can't absorb information, whether it's counselling or a talk about nutrition," Ms Ferguson said. Medical treatment is covered by the Ontario Health Insurance Plan.

Family coordinator Margaret Muir, quickly brings husband, children, a close friend, roommate, or other supportive people in the woman's life into the treatment plan. The program also includes talks, films, group discussions, individual counselling, and guidance on nutrition, relaxation, fitness, and assertiveness.

Most of the five counsellors are recovered alcoholics, with whom the women can identify without fear of encountering a judgemental attitude. A close two-year followup is a key component of the program.

The women are also referred to Alcoholics Anonymous. Ms Ferguson: "We try to get them involved in supportive activities" — and, for the first year, they return to the centre every week. Staff also check with other agencies to which they have been referred.

So far, results are encouraging. One early applicant, for example, was a woman about 55 years old who was almost denied admission because she seemed to have such severe brain damage. She has done so well her family has taken her back; she has remained sober, takes pride in her appearance again, and is functioning and happy.

The centre charges $300 for the day care program and is proposing a $1,100 charge for the 28-day residential program, "unless we can raise more funds. But, we won't turn anyone away because they cannot afford the fees," Ms Davison said.

Ontario treatment services for women

TORONTO — The Jean Tweed Treatment Centre considers its target population to be the estimated 22,000 women alcoholics in Metro Toronto.*

With an estimated 70,000 women alcoholics in Ontario, the province has treatment services exclusively for women addicted to alcohol and other drugs in 12 centres. The current total is 117 treatment beds for in-patients, plus day care programs varying in extensiveness. The Tweed centre's proposed 15 beds will bring the total next fall to 132.

In-patient services for women are located at Waterloo, Kenora, Oshawa, Ottawa, Windsor, Sudbury, Beaverton, and Toronto. Most of these facilities also have day care programs. In addition, day care programs are available in Cambridge, St Catharines (two centres), London, and at second centres in Sudbury and Ottawa.

Some other treatment services accept women in mixed day care programs.

In Metro Toronto, a Salvation Army recovery home with 18 beds accepts women between 16 and 60 years old at $9.50 a day, although "inability to pay does not preclude admission."

Renascent Treatment Centres has a women's house with 14 beds, charging $200 for a 28-day treatment.

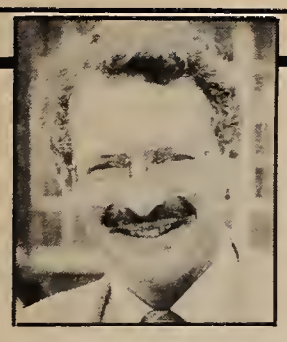
There are women's detoxification centres in Ottawa and St Catharines, with a third approved for Windsor, an Ontario Ministry of Health spokesperson says. Sault Ste Marie has a halfway house.

Alberta has a treatment centre and a halfway house in Calgary; British Columbia has two centres for women, in Vancouver and North Burnaby; and Manitoba has a women's treatment centre in Winnipeg.

**(Statistic from the Addiction Research Foundation 1978-79 annual report.)*

NEXT MONTH
Alcoholics Anonymous 50 years on

COMMENT



GILBERT

'What would it take to reduce Toronto's cancer mortality rate to near zero?'

A community free from avoidable cancer

By Richard Gilbert

Toronto's Medical Officer of Health, Dr Alexander Macpherson suggested to me that our situation in the 1980s in respect to avoidable cancer is similar to that faced by Torontonians in the 1880s in dealing with bacterial disease. I pursued the thought during a presentation to the Terry Fox Workshop on Priorities for Cancer Prevention in Ontario, held in Toronto in April (**The Journa**l, May).

Just over 100 years ago, the City of Toronto began to get serious about public health. In 1884, the newly-appointed, first full-time Medical Officer of Health, Dr William Canniff, and six "sanitary police" began a full scale attack on bacterial sources of disease. These officials ordered and secured the cleaning up of yards and cellars, and the cleaning of drains, privies, and water closets. Fouled wells were filled in, and city water was piped in instead. Milk and other foodstuffs were inspected, as were dairies, dairy farms, and slaughterhouses. Children with contagious diseases were banned from school. Free smallpox vaccination was made available.

Dr Canniff's successors massively extended these programs to reduce bacterial infection. Special attention was paid to sewage treatment and water purification.

Dramatic results

The results were dramatic. For example, after completion of a trunk sewer and filtration plant in 1910, and the beginning of chlorination of the water supply in that year, the death rate from typhoid in Toronto fell from 41 per 100,000 in 1910, to 8 per 100,000 in 1914.

Here are some landmarks in the elimination of bacterial disease in Toronto:

1932 — disappearance of smallpox from Toronto;

1933 — first year with no deaths from measles;

1934 — Toronto became the first large city in the world to have no deaths from diphtheria;

1942 — no further deaths from typhoid.

The progress over 60 years against the ravages of bacterial disease in Toronto was not smooth. There was opposition all the way. Here are some examples:

1886 — (and again in 1888) voters rejected a proposal to dump sewage in the lake only where it could not contaminate the water supply;

1901 — an official study dismissed sewage treatment as unnecessarily complicated and expensive;

1907 — voters rejected plans to construct a trunk sewer and filtration plant.

Public opinion

Eventually, public opinion (and that of certain experts) changed. The benefits of controlling bacterial disease — both for public health and for the city's economy — became readily apparent. It was a long battle that continues today.

The death rate from cancer among Toronto residents in the 1980s is in the order of 150 per 100,000 — ie, nearly *four times* the rate just quoted for deaths from typhoid in the year 1910. The rate for lung cancer among males — about 55 per 100,000 — is itself higher than the earlier rate for typhoid. (The present lung cancer mortality rate among females is about 10 per 100,000.)

What would it take to reduce Toronto's cancer mortality rate to near zero between the 1980s and 2030s, as our predecessors did for deaths from bacterial disease between the 1880s and 1930s?

Reducing cancer mortality to zero involves doing two things: preventing avoidable cancer; curing unavoidable cancer.

According to British epidemiologists Richard Doll and Richard Peto, some 75% to 80% of cancer deaths in most parts of the United States in 1970 could have been avoided. Assuming this estimate has application to Canada and Ontario, and to Toronto in particular, Toronto's death rate from cancer could be reduced from 150 per 100,000 to about 35 per 100,000.

Drs Doll and Peto suggested the following approximate distribution of factors contributing to avoidable deaths from cancer:

1	Diet	35%
2	Tobacco	30%
3	Infection	10%?
4	Reproductive and sexual behavior	7%
5	Occupation	4%
6	Alcohol	3%
7	Pollution	2%
8	Other/unknown	9%?

(Other includes food additives, industrial products, geographical factors, including sunlight, medicines, and medical procedures.)

They suggested that general over-nutrition should perhaps come first on the list of aspects of diet that may affect the incidence of cancer. Certainly, the correlations between body weight and cancer mortality are impressive, especially if lung cancer — which tends to occur in thin smokers — is not included. Also impressive are the more specific correlations between the incidence of cancer of the colon in men and their meat consumption, and between breast cancer in women and their total fat intake.

Second on the list should be specific under-nutrition in respect of protective food elements — notably fibre, vitamin A, and beta-carotene. Other dietary factors — including natural carcinogens in food, carcinogens produced during cooking, and carcinogens used as food additives — seem to be of small significance.

Chief obstacle

The chief obstacle to eliminating dietary causes of avoidable cancer is ignorance. Most people do not know that eating too much non-fibrous food, especially fat, and too little fibre increases their chances of dying from cancer. (There is some awareness that diet and cancer may be related — but concern is mostly about "the stuff they put in our food" rather than about the food itself.)

Massive education programs in schools and in the media are required as the first steps in reducing ignorance about the dietary causes of cancer. If the programs do not work, more dramatic steps may be necessary if avoidable cancer is to be avoided. These might include labelling fat-containing foods with cautionary warnings, regulations requiring upper limits on fat content and lower limits on fibre content in many foods, differential taxation and subsidization, and possibly even compulsory exercise classes for the sedentary.

The reality of attempts to legislate healthy dietary practices will include strong resistance both from food manufacturers and from consumers — if indeed the likely result of such legislation were to be reduced consumption and reduced sales. Meat and dairy industries would argue that their businesses were being interfered with and their right to earn a profit was being curtailed. Food retailers would plead poverty. Consumers would complain about higher prices, about restrictions on their choice of foods, and about government interference with their inalienable right to eat what they want and as much as they can of what they want.

Opinion advance

I suspect that by the time public opinion is advanced enough to require the following:

- maximum meat content in hamburgers to avoid excessive fat intake;
- minimum fibre content of hamburger buns;
- maximum hamburger cooking temperature to avoid carcinogen formation;
- a tax to reduce total hamburger consumption; and,
- compulsory exercise prior to eating each hamburger;

the legislation will be unnecessary, because few hamburgers will be eaten — for health reasons. The problem now is that most dietary awareness is related to vanity rather than to health. People choose their foods wisely and limit their intake in order to look better. Health could be a stronger motivation. If the word gets around that general over-nutrition and specific under-nutrition contribute to cancer, attempts to induce people of all ages to eat better will likely be more successful.

Spoon-feeding necessary

The current attitude of government in Canada to diet seems to be summed up by this excerpt from the 1973 preliminary report on the Nutrition Canada national survey:

> "In spite of all that government and industry can do, the ultimate responsibility lies with the consumer. Consumers should make it their business to acquire reliable nutrition information and to selectively promote nutritious foods and reject foods that offer little nutrition. Consumers should not depend on government to spoon-feed them information, nor should they be misled by excessive promotion of goods of questionable nutritional value."

As far as the dietary contribution to cancer is concerned, spoon-feeding of information by government is just what *is* required. The primary responsiblity lies with local public health departments, as it did decades ago when the drive to eliminate death from bacterial disease was gathering steam. Fortitude was required to overcome the powerful resistance to good hygiene. The promise of good health was the main weapon, as it must be in freeing Toronto from avoidable cancer.

Tobacco use

1983 was a landmark year in cigarette consumption in Canada. For the first time for decades, there was a major decline — by 6% — in the number of cigarettes smoked per capita. It was caused by large increases in federal and provincial taxes on tobacco during the previous two years — amounting to 19% after adjusting for inflation. The real increase in provincial tax in Ontario between 1981 and 1984 was 29%.

I wrote a column at the time — *The tobacco industry is right* (**The Journal**, May, 1984). My point was that consumption had gone down not because of Health and Welfare Canada's cessation programs, as had been suggested by Monique Begin, then federal health minister, but because of the dramatic increases in taxation — the reason given by Jacques LaRiviere of the Canadian Tobacco Manufacturers Council.

Taxation is certainly an effective means of limiting cigarette use. The Ontario Council of Health's task force on smoking and health argued in 1982 that taxes on tobacco should be raised enough to halve per capita cigarette consumption. Specifically, tax increases causing a doubling of the retail price of cigarettes were proposed, to be phased in over a year. This would have brought the price of cigarettes in line with that in Sweden, where cigarette consumption is half that in Canada.

The reality of tax increases is powerful opposition from the tobacco growing and marketing industries. These forces have already had their impact on the Ontario government, which, for the moment, appears to have abated further increases in tobacco taxation. However, a sharp increase in the federal tax in May this year should ensure a continuing decline in cigarette use.

The power of the tobacco interests is not simply their ability to finance the election campaigns of particular politicians. Tobacco industries directly employ tens of thousands of workers in Ontario and Quebec. The livelihood of thousands of variety drug-store operators depends in considerable measure on the sale of cigarettes. The interests of these voters cannot be ignored by government.

If avoidable cancer is to be avoided in Toronto, we must become a city without tobacco. A municipality does not have the means to tax tobacco out of existence, and certainly not to compensate employers and workers in the tobacco industries for their loss of livelihood or better, redirect their energies. These ends require clear and determined actions on the part of provincial and federal governments.

Toronto's contribution to the eradication of this cause of avoidable cancer can be and is being carried out in four areas:

- bringing up a non-smoking generation. The public health department is making a major thrust toward this objective;
- making it difficult for juveniles to obtain cigarettes. Stiffer licensing requirements for corner-store owners are being studied;
- restricting smoking in public places. Toronto was one of the pioneers in Canada; and,
- restricting smoking in the workplace. Toronto City Council plans to do this in September.

When San Francisco moved to restrict smoking in the workplace in 1983, there was massive and almost successful opposition from the tobacco industry. Curiously, the similar move in Toronto in 1984 and 1985 has met with no such resistance. This is a singular exception. Generally, it is true to say that had the ownership and operation of the foul wells of the 1880s been as centralized and organized as the tobacco industry is today, we might still be living without pure water in our cities.

Other factors

On reviewing current views of the causes of avoidable cancer, I was surprised to see how little was attributed to occupational exposure and to pollution. Certainly, these sources are of great concern to us in Toronto as we live each day with chemical and other industries in our midst, with water drawn from a lake that is used as a sewer, and with an unhealthy concentration of automobile exhausts.

Concern about industrial pollution is mostly confined to two areas of Toronto — the Junction Triangle and its surroundings, and the area north of the eastern docks. No clear pattern is evident in the statistics of mortality from cancer among residents. The former area tends to have a better-than-average record, while the latter area tends to be one of the three worst in the city. The other two bad areas are the downtown business district, where few people live, and around Yonge Street, just north of Bloor. I suspect that automobile exhausts are the major factor here, and that the quest to free Toronto from cancer will eventually have to include restrictions upon automobile use — possibly a more unpopular move than any mentioned so far.

A city free from cancer

As well as determined political action, freeing any community from cancer will require a lot of public investment. We will all balk at the cost, as our predecessors balked at the cost of sewer improvements. Now we can ask whether Torontonians could have afforded *not* to have eradicated typhoid. I hope that those of us alive in the year 2035 will be in a position to ask the same kind of question about avoidable cancer.

PARENTS

Elda Hauschildt reports from the PRIDE CANADA conference in Saskatoon

Police need help of parents: RCMP

SASKATOON — Parents waiting for police to solve Canada's drug abuse problems are waiting in vain, a Royal Canadian Mounted Police (RCMP) narcotics officer told the first national meeting here of anti-drug parents.

"If you've been expecting that police forces are going to solve the drug abuse problems in this country — by themselves — you might as well stick your head right back in the sand where it belongs," said Corporal Ken Azzopardi, RCMP Saskatchewan narcotics intelligence coordinator.

"Police forces in this country will never, ever, solve drug abuse problems by themselves. It takes education; it takes the development of positive lifestyle skills by ourselves and our young people.

"Enforcement has to be there, but alone it's like beating one's head against a wall."

Cpl Azzopardi lectured 350 adult delegates in the opening address of PRIDE CANADA's (Parents' Resource Institute for Drug Education, Canada) national conference at the University of Saskatchewan (U of S). He also led three workshops, two for more than 200 youth delegates.

Drugs are money, Cpl Azzopardi told the adult meeting. He noted the RCMP estimates the retail value of illicit drugs in Canada is more than $9 billion, more than $5 billion of that in cannabis products.

"A lot of Canadians have a misconception of what the drug scene is in Canada," Cpl Azzopardi said.

"We've watched a lot of United States news reports, movies and drug abuse films. We say, 'no, not in Canada,' or 'things are different in Canada.'

"I'm here basically to tell you they are the same. The drug scene in Canada is just as bad as in the US, or worse. We are a smaller population, so it doesn't appear as bad."

A PRIDE-Atlanta contingent gave details of the growth of the US parent movement, including its origin with a small group of parents active at an Atlanta high school in the late 1970s. They outlined their plans of attack in getting other parents, schools, and legislators to let them participate in drug education programs.

Ian Macdonald, MD, administrator of the US Alcohol, Drug Abuse, and Mental Health Administration and a pediatrician, told the parents how to recognize the five progressive stages in adolescent drug and alcohol abuse.

He listed: getting the drug message; experimenting and learning about mood swings; seeking mood swings; preoccupation with mood swings; and, "burn-out," or doing drugs "to feel okay."

Dr Macdonald explained not every child goes through each stage progressively.

"There are subtle changes. It doesn't happen overnight with children . . . Some people don't go through all the stages. Some stop at stage one and go back; some stop at stage two and go back. When you get to stage three, it is very, very difficult for a child to turn around.

"But, I've seen young people who had no drug experience at the end of the school year and, by October, were in serious difficulty."

James Blackburn, PharmD, dean of the college of pharmacy at U of S, referred to Saskatchewan's joint committee on drug utilization. Since 1978, committee members — representing the Saskatchewan Medical Association, the College of Physicians and Surgeons, U of S college of medicine and college of pharmacy, and the Saskatchewan Pharmaceutical Association — have been studying the "rational use" of prescription drugs.

The province's program covers the entire population of one million people. The joint committee studies and analyzes data on drug use, making recommendations on how to deal with problems as they are identified.

As well as addiction and health specialists, PRIDE's conference included local, provincial and federal politicians.

Azzopardi: many misconceptions

Canadian direction uncertain

Parent group on pioneer ground

(from page 1)

years of struggle they did, because we're drawing on their experiences," Mrs Opheim said. "They went through the agonizing, the growing pains — the media putting on their own labels, calling them vigilantes, things like that."

While PRIDE is covering "pioneer ground" in Canada, and no one is certain what direction a parent movement in Canada might take, the emotional response of delegates here made Mrs Opheim look to rapid growth.

Response was especially strong for the US contingent — Marsha Manatt Schuchard, PhD, and Thomas Gleaton Jr, EdD, co-founders of PRIDE-Atlanta; William Rudolph, MEd, principal of Atlanta's Northside High School; and, William Oliver, president of STRAIGHT, Inc, a treatment program. Each related personal experiences in meeting drug abuse problems in the home, school, and community. Parents, teachers, and health educators reacted well to their suggestions on how to mount community programs.

Mrs Opheim said delegates appeared to need to connect physically. "I've had so many people come up and touch me," she said.

"I think this is the first national conference on youth and drugs. So, it was the first time whoever they were — whether they were teachers or others extremely concerned and caring, or whether they were parents — were able to share."

Mrs Opheim said three distinct parent groups — those interested in prevention, those in intervention, and those "reaching out because they have already lost their child to drug abuse" — came away with sufficient information and materials to sustain the momentum.

PRIDE US officials say they are committed to helping PRIDE CANADA with organization, networking, surveys, etc. But, they insist it is the idea of parental involvement in drug education they are trying to export, not their 'made in America' approach.

Dr Gleaton, PRIDE's US executive director, told **The Journal**: "The thing we're talking about can work as well in Atlanta, Montreal, or the bush of Africa, because what we're looking at is that protective instinct of mothers and fathers to protect their young.

"Now, it doesn't matter whether they're protecting them from famine — so evident when you watch television today and see that mother who is dying from starvation, holding onto that baby who's still nursing, trying to help him survive. If they will fight that hard in a famine, they'll certainly fight hard to help — if they understand the dangers the child's in — with drug abuse.

"And, that's what we're looking at; we're pulling from that innate protectiveness we have as parents."

PRIDE CANADA is confident enough of growth to have scheduled its second national conference for Saskatoon in May, 1986. By then, organizers should know whether a parent movement in Canada has taken hold.

University administrators face liquor lawsuits too

TORONTO — Ontario University administrators are liable to lawsuits like any liquor licence holder, a law professor told a recent CAPE symposium.

Robert Solomon, of the University of Western Ontario, explained a 1983 ruling to university administrators here. The case involved a 16-year-old passenger who became a quadriplegic after an accident. He and his family successfully sued both the driver, who had been drinking beer in a hotel, and the hotel, for more than $1,390,000. The hotel was sued as a provider of alcohol for breaching "its obligation to control the conduct of one of its intoxicated patrons."

Professor Solomon said: "The clear trend in the law is toward the expansion of liability for all those who sell or supply alcohol to others." For universities, "if the liquor licence under which a student event occurs is under the auspices of the university, then the university may be liable."

Based on the case cited and other recent rulings, "there is every reason to believe that a tavern owner's liability will be extended, the size of the damage awards will increase, and the number of claims will rise dramatically," he said.

This could apply to all of Canada, Prof Solomon told **The Journal**. In the United States, there are even more cases as "this is a hot issue in many jurisdictions."

Ottawa promises action

SASKATOON — Canadian government House Leader Ray Hnatyshyn has made a commitment that the federal government will step up its drug education and control programs.

"We will attempt to improve the quality and quantity of information to parents and professionals," he told the PRIDE CANADA conference here.

"One particular area of emphasis is the provision of parent drug education packages geared to low income, 'information poor' parents," he said.

"At the international level, we have and will continue to play an important role, through the United Nations Commission on Narcotic Drugs, in controlling the production of drugs, and illicit trafficking."

Mr Hnatyshyn also read a telegram from Nancy Reagan, wife of United States President Ronald Reagan and highly visible advocate for the US parent movement against drugs. Mrs Reagan praised the Canadian parent movement's formation and offered encouragement that it will grow.

Wanna make a top-grossing drug flick?

By Wayne Howell

From: *Universal Talent Agency*
To: *Members of the American Producers' Association; Members of the American Film Directors' Association*

We al Universal Talent Agency are proud to announce a new and innovative service that makes packaging and producing a top-grossing drug flick both easy and pleasurable. Come to Universal for your next *Beverly Hills Cop*, *Fletch*, *Stick*, or *Mike's Murder*, and check out our collection of talent and expertise. We offer:

** ASSORTED MINOR HEAVIES **
Universal has under exclusive contract a fine stable of minor heavies for intimidations, beatings, car chases, shoot outs, and the like.

Our Latinos are selected for squint-eyed surliness and general scruffiness. Versatility is the key-word with our Latinos — all of them can do Cuban, Colombian, or Mexican.

Our inner-city blacks are selected for coolness and cruelness, in equal proportion. And, we are extremely proud of our WASPs, all of whom come with some distinguishing physical characteristic (one eye, albino skin, tattoo, etc) to nicely accent their vicious and degenerate natures.

But, that is not all. We also offer a full line of orientals, Middle-Easterners, and shifty-eyed Europeans.

Come and check out our Minor Heavy Line. If it's villians you want, Universal has got them. And each and every one of our minor heavies is trained in:

- hanging around and appearing mean,
- looking furtive in bars and/or telephone booths;
- driving wildly about the major city of your choice; and,
- dying in spectacular fashion during climactic shoot outs.

** ASSORTED MISTER BIGS **
Universal is very proud of its exclusive designer-line of Mr Bigs. Choose from the Godfather collection with its svelte Mediterranean look. Choose from the lean aristocratic jet-setter collection, from the somewhat swarthy Levantine line, or from the ever-so-popular, all-American Kiwanis Club or Californian sybarite collection.

It really doesn't matter which Mr Big you select, because each and every one of our Mr Bigs is carefully selected for his subtlety, his sophistication, and his good manners.

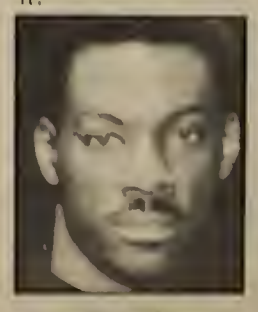
It doesn't matter whether he is playing the police chief, the mayor, the big businessman, or the corporate lawyer, the audience will never suspect this nice man is Mr Big until the shocked hero sees him in the company of the minor heavies, in a bar, on a boat, or on the freeway.

Universal offers more — much more — than just Minor Heavies and Mr Bigs.

For instance, we have a whole library of stock footage of cars driving around on freeways, and suspicious-looking people dialing telephones. This footage comes with a 1950s jazz overlay or a hard rock sound track — the choice is yours.

And, in the unlikely event you don't have a *bona-fide* box office draw such as Eddie Murphy, Burt Reynolds, or Chevy Chase to play the enterprising hero, Universal has a small exclusive line of male protagonists capable of doing whatever stock turn (Vietnam vet, aging hippy, intrepid journalist) will meet your needs.

So remember: if you want to make it mindless, and make millions, give Universal Talent Agency a ring. You won't regret it.



Box office hits: Murphy, Chase

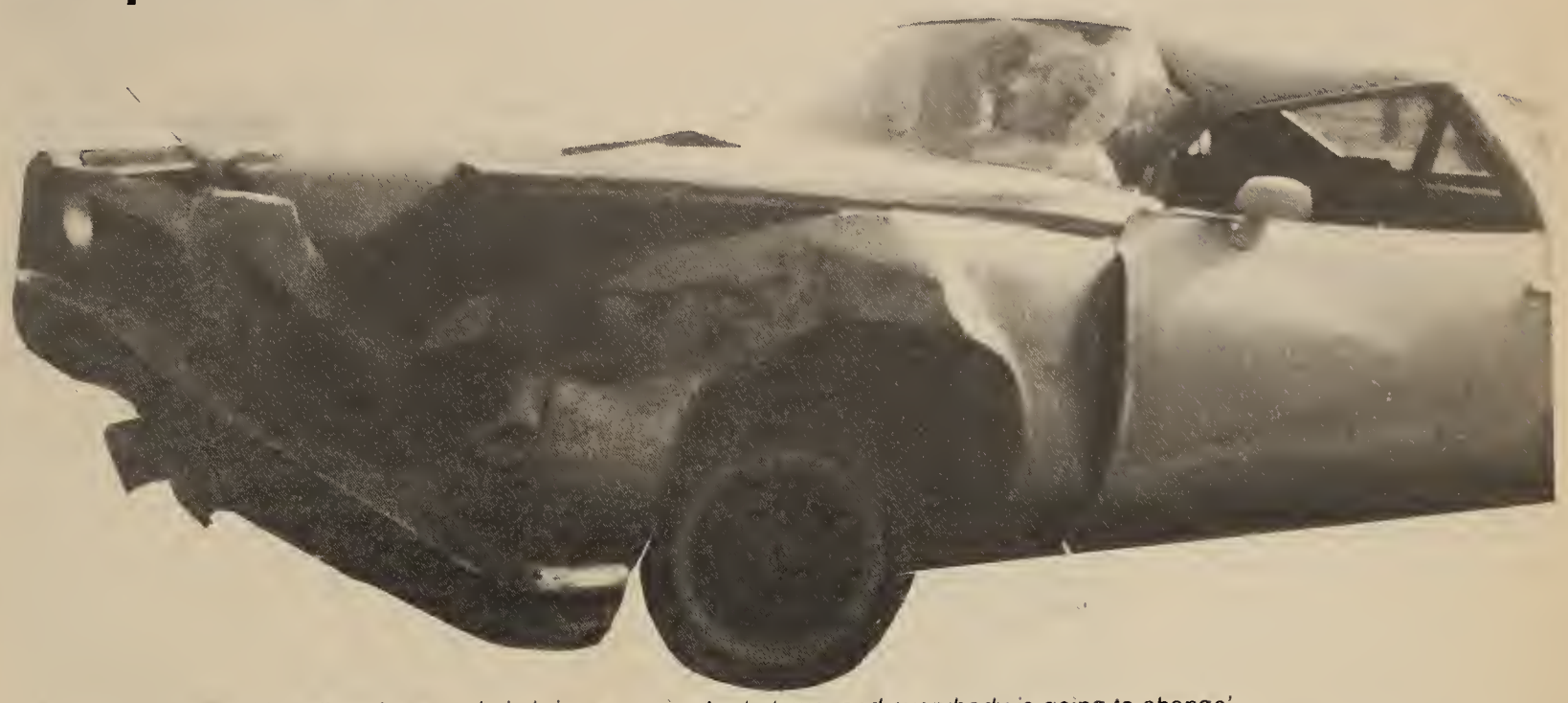
FEATURE

Mandell at Washington policy forum:

Public expects alcohol policy to see-saw

The alcohol policy pendulum again swings in the United States; the direction is increased restrictions. But, while there is no question of initial success, this will soon dissipate, if history is a guide.

Some of the ramifications of control measures and of educational and prevention programs were put forward by speakers at the recent US National Invitation Policy Forum, overseen by the Alcohol and Drug Problems Association of North America, and held in Washington. Contributing editor **Harvey McConnell** *reports.*



Drunk driving: 'they think all we have to do is bring a movie star to town, and everybody is going to change'

WASHINGTON — Drunkenness has been considered a major social and legal problem since the founding of the American colonies, pointed out Wallace Mandell, MD, professor of public health, and director of alcoholism treatment, Johns Hopkins Hospital School of Public Health, Baltimore.

The 13 original colonies produced a grain surplus and served as an outlet for Britain's surplus alcohol. However, there was always a shortage of manpower, so laws regulating alcohol use were passed across the spectrum, and included prohibition. Each time, there was initial success; each time, it quickly dissipated.

Family disruption

Dr Mandell added: "During United States history, periods of high levels of consumption have been followed by public recoil and political action to reduce the levels of consumption."

"Initially, such reactions involved attempts to influence individuals to decrease or discontinue alcohol consumption. We are in such a period today."

When the cost of social problems increases — particularly family disruption, public intoxication, and lowered productivity — moves are made to control those who sell alcohol. If this fails, then a wave of prohibition sentiment, and sometimes action, can set in.

Dr Mandell: "During a period of rising problems, the citizens are willing to say 'at any cost, we must reduce the level of consumption.' As levels of consumption come down, the public says 'wait a minute, this is costing the economy too much; it is causing problems in the tax revenue structure.'

"As these costs mount, general public reaction against controls is joined by other sectors of society, who believe it is advantageous for the economy and the tax structure to return to alcohol use."

Sanctions can work — at a price. Studies of various crimes demonstrate behavior can be changed, and this could include driving while drunk or illegal use of alcohol.

The obverse is "you have to drive the police enforcement rate up very high," Dr Mandell said.

Experience with the breathtest laws in Britain, New Zealand, The Netherlands, and Sweden, for example, shows the impact immediately after they come into force is a reduction in driving while impaired (DWI) offences. But then, Dr Mandell hypothesized, "it generally takes the public two years to figure out there is no certainty of being caught," and the DWI rate starts to rise.

It has been calculated that one would have to drive intoxicated between 200 and 2,000 times before being caught once. The chance, once being caught, of suffering even a mild punishment, is only 50-50.

There can be temporary successes. The state of Maryland, for example, has in recent years run a number of campaigns advertising road blocks and increased police activity, in a push against drunk drivers. There will certainly be immediate success, Dr Mandell said.

Thus, individual behavior with regard to alcohol problems behavior can be influenced by legal deterrents but this, in turn, depends on high levels of police involvement and enforcement.

The overriding concern of political leaders at every level of government has to be balancing control policy, particularly enforcement, against potential social discontent against legal institutions.

Local leaders are more responsive to moral values and problems, and to balancing the benefits of the cost with control policy. National leaders seem to be responsive to national economic benefits, and to trying to balance health and property costs and revenue issues, particularly in urban areas.

Dr Mandell said people resent control being placed on them by a government they feel is distant. But, if people think the government is supporting their beliefs that alcohol is destroying social cohesion, then they will support controls and, possibly, prohibition.

Central government imposition of control policies on local government may work well, or it may create problems. Dr Mandell said he is moving to the view that government should respond to conditions which are actually being faced in a particular area.

Young congregate

Evidence is that rates of alcohol-related problems increase as rural populations move to cities. This results in large numbers of young people congregating in large groups; they are less regulated by informal institutions of social control, and they develop their own standards, including increased use of alcohol and other substances.

Ingrid Deeds, MD, director of educational programs for the American Red Cross, said specific educational programs can work but can take a long time to provide benefits, and can be costly.

An excellent example, and one of the most successful programs in US history, is the decade-old program against hypertension. There is solid evidence it has worked, and that people have identified the problem, seen a doctor, and kept their hypertension under control.

However, a major problem for many programs is that those in charge choose the method of education first and then assume it will work.

For example, Dr Deeds said, they may think about producing a movie about drunk driving which is aimed at changing the behavior of high school students. "All we have to do is get a movie star to town and everybody is going to change, they think, incorrectly."

Or, the concept may be a major advertising program, with a number of newspaper and television spots telling people they should not do this or that. The belief is that as a consequence of such a campaign, people will change their behavior.

Dr Deeds believes "overall, behavior is hard to change. It is complicated, affected by many variables, therefore is not easy to change, and it takes a lot of time."

The aim should be a meshing of education and prevention, in a logical sequence to elict a voluntary adaptation in behavior, within a planned sequence of events.

For example, "it is easy to get people to do things — millions of smokers quit for a day, a week, or a month. The trick is to stay off it, to really support that behavior change."

Behavior never changes in a vacuum, which is why social support and reinforcement is vital in almost any education prevention model one can think of.

Time and money

Dr Deeds noted that the cosmopolitan can be influenced by advertising campaigns, but the majority of people are keyed to inter-personal influences, and for them the media do not suffice.

Mass-media campaigns need to be followed by intensive community-level intervention by church groups, social groups, and family groups. It takes time and money to coordinate such groups.

There are snags as well. Some young people, with smoking and drinking for example, see rewards in just such negative behavior.

Dr Deeds said she had heard of one educational program on the local level which seems to work. A Red Cross chapter in a small, rural community had recorded 37 deaths the previous year at high school graduation time.

Enlisting the help of some students, the chapter put a wrecked car outside the school and covered several students in the wreckage with mock blood and gore. Firemen and ambulance people were also called in.

Dr Deeds said the rest of the school's students were invited to inspect the wrecked car and their "injured" peers. The following year, only two deaths in the same age group were recorded in the county.

She added: "This is impressive. While statistically I am not sure it may hold up, it is an interesting local solution to this kind of problem, and they are going to continue to do it."

Students: it's easy to get people to do things — millions of smokers quit for a day, a week, or a month. The trick is to stay off

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Hollobon joins TJ

Hollobon: 'new area'

TORONTO — Joan Hollobon has joined the staff of **The Journal** here, as contributing editor.

Medical writer for *The Globe and Mail* for over 25 years, Ms Hollobon is well-known in medical and journalistic circles.

Content, a magazine for Canadian journalists, called her a "master medical writer" in a recent article on her retirement from *The Globe*. The Ontario Medical Association will make her an honorary member at its August meeting.

Ms Hollobon says she is looking forward to learning more about the addictions field — "a whole new area of medicine" to her, and to working for **The Journal**, "a publication I respect."

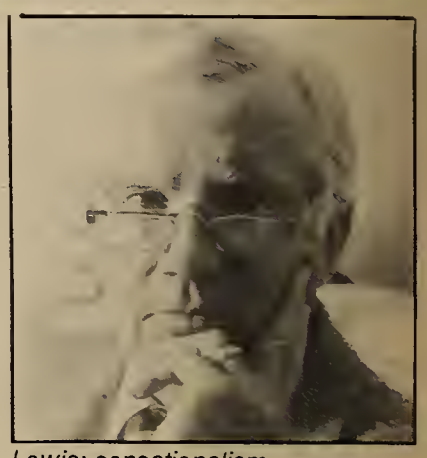
Ms Hollobon joins long-time contributing editors to **The Journal**, Harvey McConnell (Washington) and Karin Maltby (Toronto).

Lewis called to task

Dr Lewis has weakened his message (Female smokers defy warnings, Letters column, May) by introducing it with an unfounded and simplistic reference to the relative strengths of male and female intelligence. The unfortunate rise in female smoking rates and incidence of lung cancer concern many people, but the causes of these increases are complex and varied.

A good writer does not have to resort to sensationalism to capture his readers' attention. Some balance and maturity in his comments would have made Dr Lewis' letter more palatable and raised his concerns more effectively.

Janet Durbin
Education Resources Division
Addiction Research Foundation
Toronto, Ont



Lewis: sensationalism

We help him 'keep in touch'

This has to be terribly congratulatory. I find **The Journal** immensely informative and wide-reaching. It appears to cover the "world news" in our field and, as such, keeps me in touch with what is going on. It is essential reading for me, among all the material I take. And, I also enjoy it.

Two examples of information useful to me in a recent issue were: an item about a video on the dangers of smoking, aimed at primary school children, and which might be useful in the Jersey School System; and, as I am based half-time in Italy, a notice of a conference in Rome that would not have come to my attention if it hadn't been in the Coming Events column.

I look forward to continuing my subscription, and expect to have a "story" to submit to you soon for possible publication.

Patrick Lucas
Channel Islands, Great Britain and
Sinalunga, Italy

KI information sought

In the February issue, Richard Gilbert (page 5) mentions his use of the Knowledge-Index (KI) provided by Dialog Information Services of Palo Alto, California.

I would deeply appreciate being sent the full address of this organization.

Thank you very much.

Dr Robert A. Cunningham
Kisarazu-shi, Japan

(Ed note: The address of Dialog Information Services, Inc is 3460 Hillview Ave, Palo Alto, California, USA, 94304.)

Gilbert: knowledge index

We shock his boots off

Keep up the good work. Your newspaper shocks the boots off me. Why don't more people subscribe in churches, so they'll know they have more reasons for keeping up their struggles?

My hobby, now a business, is making meetings, training sessions, conferences, and conventions more exciting and more productive. Surely the stakes are so high that creativity is needed in the field. Can we dialogue about this? An idea is a terrible thing to waste — in your field especially.

New loyal reader
Charlie Clark
Yankee Ingenuity Programs
Kent, Ohio

Welcome Fort Frances High School

Please enroll the Fort Frances High School Special Education Dept in a subscription for **The Journal**. We were just made aware of its existence, and it looks super. It will be put to good use
Len Grupp
Fort Frances, Ont

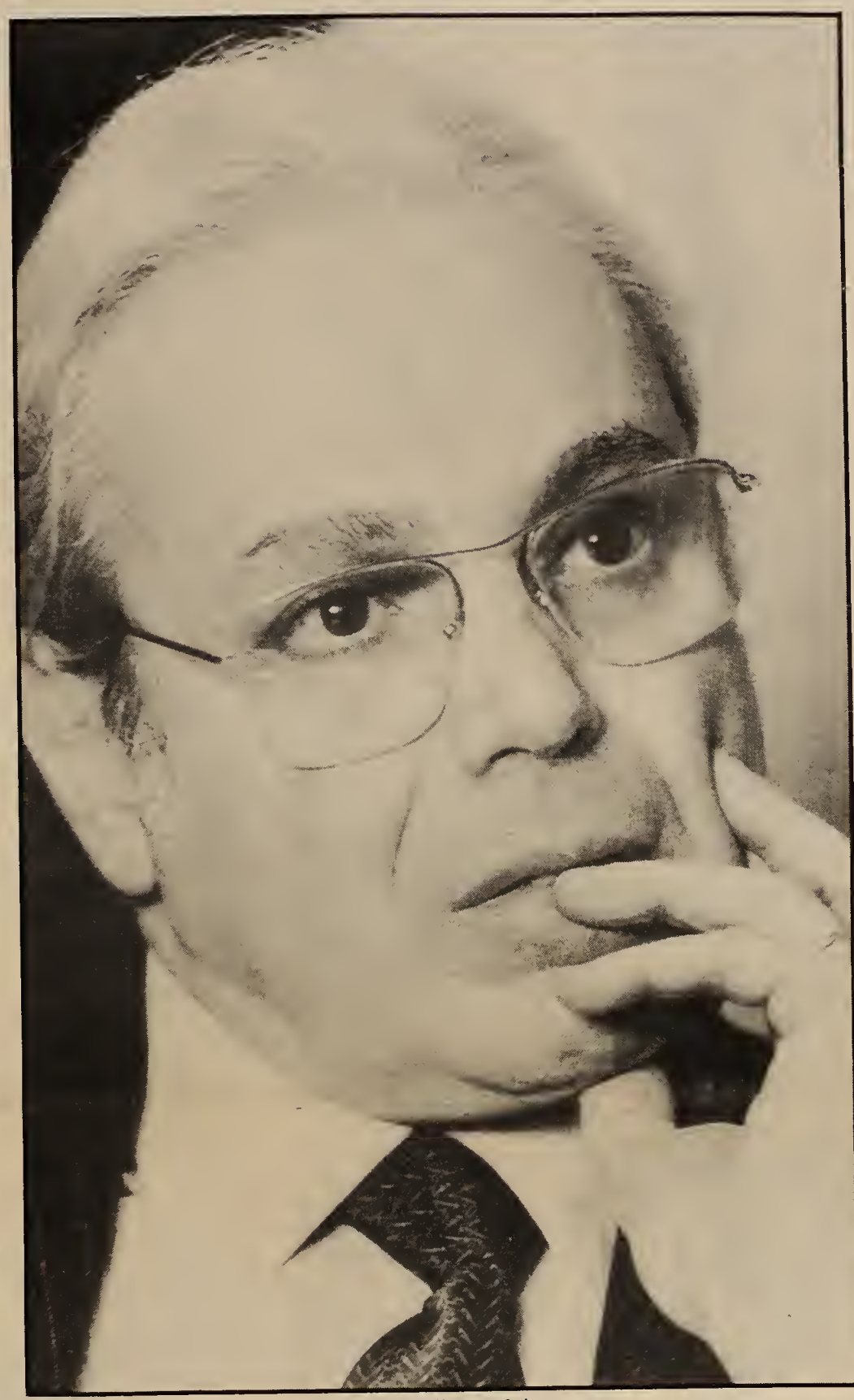
The Journal welcomes Letters to the Editor. Letters, bearing the full name and address of sender, may be sent to:
The Journal, 33 Russell Street
Toronto, Ontario, Canada
M5S 2S1

UN chief wants new offensive on drugs

Increasingly, countries around the globe are expressing alarm that drug-related problems are mushrooming beyond control. At the same time, United Nations Secretary General Javier Perez de Cuellar has been voicing concern about world drug problems.

Late in May, he carried his message, and that of many countries, to one of the highest levels in the UN, the Economic and Social Council (ECOSOC). Made up of members elected by the General Assembly (GA), and acting under the direct authority of the GA, it is the political and legislative body responsible for all UN economic and social activities, including drug abuse.

Following is the text of the secretary general's statement:



Perez de Cuellar: insidious, devastating effects of drugs

Drug abuse presents as destructive a threat to this and coming generations as the plagues which swept many parts of the world in earlier centuries. Unless controlled, its effect will be more insidious and devastating.

I spoke to the third committee (ECOSOC's drug committee) in November, 1984 in appreciation of action being taken by the General Assembly to assist in the fight against drug abuse, and to indicate what I was doing to mobilize greater efforts by the United Nations' system.

I have asked to address the Economic and Social Council on the same subject because I believe an even more concerted and determined struggle on the part of the entire international community is now required. Indeed, in my view, the time has come for the United Nations to undertake a bold and new offensive to combat drug trafficking and abuse.

Illicit drugs, wherever they are produced or used, contaminate and corrupt, weakening the very fabric of society. Increasing worldwide abuse is destroying uncounted useful lives. These problems have already profoundly afflicted every region in the world.

Individual cases of drug abuse now run into the millions. Tragically, many of those most seriously affected are young people to whose concerns and interests the present year is particularly dedicated. All too frequently the abuse of drugs, often in combination with alcohol, can lead to death, bringing grief and pain to countless families around the world.

The suffering of individuals is not the only cost. Illicit drugs and crime go hand-in-hand. The allure of tremendous profits constitutes a potent attraction to criminals, and drug trafficking frequently entails other criminal acts, including bribery, larceny, the corruption of public officials, and even murder. Moreover, there may well be links between illicit international drug networks and armed terrorist groups which have sought to subvert governments.

It must also be stressed that trafficking in illegal drugs represents a heavy toll on many national economies. The cost must be counted in literally billions of dollars, traceable to the time lost in the workplace, to the substantial burden imposed on judicial and penal systems, and to the treatment and rehabilitation of drug addicts.

The personnel, raw materials, and equipment used in the illicit manufacture and transport of narcotic drugs are all too readily obtainable. Even as the demand for older drugs spreads to new markets and regions, new drugs are being developed. Many of these drugs are both easy and cheap to synthesize, and sometimes more lethal than the older ones. Thus, as we look toward the future, the potential for even more widespread danger is evident.

There has long been awareness in the United Nations of the drug menace and, with near unanimity, Member States have called for a wide range of counter-measures. Last year, the General Assembly adopted a series of resolutions including a proposal for the preparation of a new convention designed to combat more effectively the traffic in illicit drugs. Moreover, new international initiatives involving the highest levels of government have been devoted to this issue over the past year.

But, it is evident that the existing instruments and resources are inadequate to deal with a problem of such magnitude. We need a more concerted, a more comprehensive, and a truly worldwide effort to reduce the plague of illicit drugs.

I believe the moment has arrived for the international community to expand its efforts in a global undertaking to meet this peril.

I accordingly propose that a world conference be convened at the ministerial level in 1987 to deal with all aspects of drug abuse.

Specifically, the conference should be multi-disciplinary in nature and focus on the following key areas:

- the promotion of education and community participation in prevention and reduction of the demand for illicit drugs;
- crop substitution and other methods of reduction of supply;
- improved methods to limit the use of narcotics to medical and scientific purposes;
- forfeiture of illegally-acquired proceeds, and the extradition of persons arrested for drug-related crimes;
- strengthening of resources of law enforcement authorities; and,
- treatment and rehabilitation of drug addicts.

The conference should serve to raise the level of world awareness of the dangers we face; mobilize the full potential of the United Nations' system; reinforce other intergovernmental, non-governmental, and regional initiatives; and encourage governments to concert their efforts and to devote greater resources to combat drug abuse and trafficking.

I believe the United Nations is uniquely qualified to play a major catalytic role in enhancing efforts to deal with this problem.

I hope that Member States will favorably consider this proposal, and thereby give new impetus to the struggle to free the world of the deadly scourge of drug abuse. In this 40th anniversary year, such action could constitute a major contribution to the common good, in the spirit of the United Nations Charter.

FAS researchers stir health pro interest

By Harvey McConnell

WASHINGTON — Henry Rosett told **The Journal** two years ago that with forthcoming publication of his book, *Alcohol and the Fetus*, he felt it was time for him to end a decade of fetal alcohol syndrome (FAS) research and move into other spheres.

He didn't bargain that the story "would trigger off a whole slew of interest in our FAS work and, we had a number of people telling us we couldn't give it up," says Dr Rosett, professor of psychiatry at Boston University School of Medicine.

The result is that in the past year he and colleague Lyn Weiner, MPH, assistant professor of psychiatry at Boston University, have trained more than 1,700 health professionals in an education program sponsored by the Massachusetts department of health, devised an education program for a drug store chain, and collaborated with researchers at Sweden's Karolinska Institute.

Dr Rosett says they want to train health care professionals in methods of systematically taking drinking histories of pregnant women and making referrals, or providing counselling, for women who are drinking heavily and do not stop within two weeks.

They have found that about 10% of pregnant women are heavy drinkers — women who drink heavily may not be alcoholic — and about two-thirds respond to supportive counselling from prenatal care providers, who may be doctors, nurses, social workers, or midwives.

Dr Rosett adds: "We have found that when people ask systematically, in a non-judgemental way, and as part of helping them have a happy baby, they are very appreciative, they can see the importance, and two-thirds will respond."

The remaining one-third, or 3%, must be followed up quickly because "the clock is always running on the pregnancy so that if in two weeks there is no success in getting the woman to stop drinking, then she has to be referred to whatever facility is available."

Identifying the 10% of women at risk, and having two-thirds of these abate their drinking, reduces considerably the number of women who have to go to alcoholism treatment centres, or Alcoholics Anonymous, and is a much more manageable load.

Ms Weiner said that when the teaching program research was originally funded, "we really weren't too sure what our reception was going to be. It turns out it has been overwhelming."

Dr Rosett and Ms Weiner have become involved with a chain of pharmacies with 111 outlets in the state, and which employs 250 pharmacists. The pharmacists loan clients an audiotape on drinking and pregnancy.

Officials of the chain suggest many of the pharmacists know their clients, see them on different occasions than doctors, and want to become more involved in health care.

Dr Rosett points out that women who drink heavily do not respond to media campaigns: "If alcoholism could be cured by posters and television commercials, it would have gone away a long time ago."

In addition, he says, "exaggerations about prevalence and about the dangers of small amounts of alcohol have interferred with the credibility of the real dangers of heavy drinking in pregnancy."

Dr Rosett says: "The fact is that all the cases of fetal alcohol syndrome in the world that I have any knowledge of have been born to chronic alcoholics. Subtle fetal alcohol effects are very hard to demonstrate, one way or another."

Rosett: 'whole slew of interest'

NEWS

Psychotherapy is better after sobriety: Bean

BOSTON — Psychotherapists and Alcoholics Anonymous (AA) sponsors should act in partnership for the benefit of alcoholics, Margaret Bean, MD, told the 8th Annual Alcoholism Symposium here.

Dr Bean, assistant professor of psychiatry at Harvard Medical School, is president-elect of the American Medical Society on Alcoholism and Other Drug Dependencies, which co-sponsored the symposium with Cambridge Hospital, Cambridge.

"One of the parlor games at AA is taking potshots at psychotherapists who don't address (members') alcohol problems," Dr Bean said, conceding psychotherapy is inefficient during active drinking and works better after 18 months to two years of sobriety.

"AA sponsors probably know more about assisting with early recovery," she said. "And, the psychotherapist is in a good position to deal with the binds that patients get in with sponsors. For example, a patient can be highly sensitive about a sponsor's availability."

Bean: AA parlor game potshots

Dr Bean said: "Many sober alcoholics see psychotherapists. More would like to, and would benefit from therapy, but they avoid it because of bad experiences during their active drinking, or because of the poor reputation of psychotherapy as a primary treatment for alcoholism."

She said some people seek psychotherapy "because of a snag in the normal recovery process" and others because "they have major mental illness as well as alcoholism."

Others want psychotherapy because of complications of alcoholism, "such as grief reactions to losses, or a kind of survivor syndrome with a need to master and integrate the alcoholism," she said. Other people want it because the situations in which they used to drink cannot now be handled by drinking.

"In the past, there was a relatively clear difference between the way feelings were handled by a person trained psychotherapeutically and a person trained as an alcoholism treatment specialist," she said. The stereotyped alcoholism worker would say, 'It doesn't matter what you feel. You don't have to drink over it. Just don't drink.' The stereotyped psychotherapist would focus on feelings and ignore the danger of drinking.

Dr Bean said such stereotypes are outmoded now, "as a more sophisticated group of people seek skills in both fields." She sees the possibility of new combined specialists who "can take a realistically complex approach to patients who defy simplistic classification."

Noting that such specialists would have to face "more questions than any of us have the experience to answer," she outlined an eight-step/five-year recovery process: get safe; get into treatment (AA or other treatment); learn how to get sober; learn why to get sober; deal with what happens when drinking stops; grieve the losses; remodel the personality developed during the alcoholism; and, undergo psychotherapy for underlying character problems.

The first five steps, she noted, may take anywhere from six months to two years, while steps six through eight may take up to five years.

"It takes a lot of work to dismantle the denial system," she said. Dr Bean underscored the importance of "undertaking therapy with shared goals with the patient." Such goals would include such aspects as AA involvement and identifying relapse tendencies.

"Helping a person renounce drinking is a powerful event," said Dr Bean. "It takes place at a crossroads and involves the pain of giving up alcohol as well as the fantasies that accompanied addiction."

Ultimately, she said, effective treatment requires the end of the relationship with the therapist.

"Then the patient has to take responsibility."

Built-in barriers exclude women from therapy

WINNIPEG — Many chemically dependent women are deterred from seeking help because most treatment programs are designed for men, says a prevention field worker for the Alcoholism Foundation of Manitoba.

"There are real barriers that exist in the current kind of treatment for women," Susan Harris told a recent seminar on Women and Chemical Dependence held here.

She said many programs are based on a 28-day residential model, which was designed for working men who can arrange with employers to take a month off. But, this is a barrier for women with children, she said.

"Women go into treatment, but they often have to leave because their child-care arrangements break down," Ms Harris said. She referred to a Canada Health Survey which showed ony 12.5% of those attending detox centres are female, and only 3.5% of those in residential treatment programs are women.

Ms Harris suggested day treatment programs seem to offer more help for women who have families dependent on them. But, she said, the social stigma of being a female alcoholic is also a barrier for those seeking help. Women who have a drinking problem are automatically assumed to be poor mothers, slovenly, and promiscuous.

As well, the medical profession often tends to take women with psychological problems less seriously, offering them prescriptions instead of help, Ms Harris explained. For the woman with a drinking problem, this can often lead to cross addiction. She cited one United States study that showed cross addiction can be as high as 40% in women.

More studies need to be done and questions answered on how best to deal with chemical dependencies in women, Ms Harris told **The Journal**. Many times a woman's dependency on alcohol or other drugs is initiated by a male, and there is a high rate of co-dependency among chemically dependent women married to alcoholic men.

She said women's psychological and biological problems, along with the lack of support most of them face on entering treatment, must be taken into account in designing programs for women.

Long-term success rate up with 100 patients

Naltrexone aids medics on drugs

WASHINGTON — A five-year study of naltrexone for opiate-dependent doctors and nurses in the San Francisco area has shown it is highly effective in long-term treatment and recovery.

"We find that naltrexone blocks opportunistic use of opiates in the work environment of the doctors and nurses, and has improved the long-term success rate of our 100-odd patients," said David Smith, MD, medical director of the Haight-Ashbury Free Medical Clinic. The study was carried out with Donald Wesson, MD, San Francisco Veterans Administration Medical Center, and colleagues.

Naltrexone was approved last November by the United States Food and Drug Administration (FDA) for general clinical use following a number of studies in recent years, including the one by Drs Smith and Wesson. Since the FDA approval, the two have conducted training programs around the country to teach health professionals about the use of naltrexone.

Dr Smith, who was attending the annual meeting of the American Medical Society on Alcoholism here, told **The Journal** that the best regimen is naltrexone administration three times a week for the first year of recovery. Subsequently, it is administered whenever the patient needs it.

"In recovery, patients talk about their drug hunger and anxiety, and, for them, high-risk situations, such as re-entry into the work environment," Dr Smith added. He said naltrexone negates the effect of an opiate, and it is non-addictive.

Referring to the increasing interest in the drug MDMA (methylene-dioxy-methamphetamine), or "ecstasy" as many call it, Dr Smith said that contrary to claims by therapists, the drug is available on the streets in San Francisco, and it is being abused. The drug is currently not under any control and is being used by some psychotherapists.

Dr Smith said: "People in psychotherapy say MDMA is not available on the streets, but that is not true. We are seeing three or four cases a month of people taking anywhere between five and 15 tablets a day over a two-day period, predominantly for the stimulant effect.

Some users of MDMA claim it gives the insight of LSD, but without the side effects. No clinical studies of its use have been published.

Smokebusters in Australia

NEWCASTLE — Hunter Region staff of the New South Wales department of health's Quit for Life anti-smoking campaign brought their slogan to the people at the 1985 fair here this spring. Using a Smokebusters theme based on the hit movie Ghostbusters, Terry Slevin and Freda Zikos donned full jungle greens and used water cannon back packs to get their message across graphically to fair-goers willing to have their cigarettes doused. The theme gained attention of the Australian media.

Native women: facing stereotypes and language barriers

Native women: dual stigma

WINNIPEG — Native women alcoholics face a double stigma in attempting to get help for themselves, a Native alcoholism counsellor said here.

Marie Baker, of the Alcoholism Foundation of Manitoba, said that Native women are often confronted by racist attitudes when they try to get help. The stereotype of the "drunken Indian," coupled with society's negative view of female alcoholics, means many native women shy away from seeking assistance.

Language barriers often contribute to the problem, especially in urban areas where most social agencies do not have native speaking workers, Ms Baker said. "They can't really explain their needs to a social worker or another helping professional."

As well, Ms Baker suggested, Native women, especially those with children, often get caught in a bind if they try to enrol in a treatment program. "In some cases, for native women to seek alcoholism treatment means losing their children (to child-care agencies)."

Many women, once they get caught in the social services system, find themselves confronted with as many as 20 different social workers trying to help them. "And, they don't let go. Sometimes the stranglehold of their help . . . leaves a woman no personal choice," she said. "You want to have choices and to be treated with dignity and respect."

Ms Baker added that Native-oriented programs designed to meet the needs of Native women should be developed and coordinated, with treatment of the Native female alcoholic involving a holistic approach and incorporating Native values.

ILO recommends industrial rehab programs

By Thomas Land

GENEVA — Special rehabilitation services established by industry for employees in danger of becoming dependent on alcohol or other drugs have proven a sound investment, says a study published by the International Labor Organization (ILO).

The United Nations (UN) organization argues that addiction problems cost national economies billions of dollars every year in lost production and material damage. Alcoholics and drug abusers on the payroll usually contribute to higher rates of absenteeism and personnel turnover, more work accidents, lower productive capacity, and quality of production.

Industry is thus assuming a key role in fighting the problem. Alcohol abuse has emerged as one of the most serious health problems in Canada and the rest of the industrialized world, surpassed only by heart disease, cancer, and mental illness. Economic costs are staggering.

In Switzerland, the cost of alcoholism on the job is estimated at 2.1 billion francs (US $823 million) annually. Estimates for the United States range from US $49 billion to as high as $120 billion every year, depending on the methodologies used.

These statistics are alarming and revealing, comments the ILO. Used as a benchmark, they can provide an insight into the situation in many other countries which have similar or even higher levels of yearly alcohol consumption.

The problem is exacerbated by what the World Health Organization (WHO) describes as the "drug epidemic." It reckons there are some 49 million illicit drug users, not including even greater numbers of people who abuse amphetamines, barbiturates, sedatives, and tranquillizers.

There are three reasons why management and unions are increasingly working together against addiction, argues Behrouz Shahandeh in the study, *Rehabilitation Approaches to Drug and Alcohol Dependence*, (ILO, Geneva, 1985) (**The Journal**, April).

- In industrialized countries, about seven of every 10 problem drinkers are employed. Circumstantial evidence suggests people are increasingly using "pep pills" on the job — often in combination with alcohol.
- Abuse of alcohol and other drugs results in absenteeism, industrial accidents, lower productive capacity, decreased quality of work, higher personnel turnover, thefts, and difficulties in working relationships.
- The workplace provides coercive and supportive influences which can be used to stem the problems, particularly when a troubled employee is faced with the option of being laid off.

The study analyzes various special services supported by management and unions, and developed to reach troubled employees as early as possible. It also describes the infrastructure and administrative services required for vocational rehabilitation and social reintegration; discusses the importance and various means of involving the wider community; provides chapters on women and drugs, and youth and solvent abuse, and gives many examples of successful schemes.

Under a joint labor-management scheme launched by General Motors in the US, for example, absenteeism among employees in the program was reduced by 40% within one year. Sickness and accidents benefit utilization for the same group was reduced by 60%. Disciplinary action taken by management against people enrolled in the program was cut by half.

The study identifies the following pre-requisites for success:

- a comprehensive joint labor-management policy with clear objectives for anti-addiction strategies;
- understanding that alcohol and drug dependence are health problems and must be treated as such;
- prohibition of abuse of alcohol and other drugs at the workplace;
- iron-clad rules and regulations on their use and abuse, control procedures, and disciplinary action to be enforced for all personnel, regardless of rank, influence, and position;
- awareness that best results can be achieved with those who seek assistance;
- confrontation of others with the problem, which may mean putting them on notice that they could lose their jobs;
- strict confidentiality to employees seeking assistance, and assurance that a plea for help will not jeopardize job security or career prospects; and,
- use of community resources for treatment and rehabilitation, because on-site services are expensive and therefore feasible for only large corporations.

Enterprises cannot go it alone, says the ILO's Mr Shahandeh. All efforts to push alcohol and other drug abuse out of the workplace must be harmonized with the struggle against addiction outside. He concludes, "The first step alcohol and drug addicts must take if they want to kick the habit is to recognize that they have a problem.

"The same goes for the workplace and for society as a whole."

Focus is now on heavier sentences

Austria tightens 1981 drug amendment

By Gamini Seneviratne

VIENNA — Austria has adopted a new drug law stiffening sentences for serious offences and easing those for first-time and lesser offenders.

In force since June 1, the new law gives federal enforcement bodies authority to search individuals and their belongings without a judge's warrant. This authority is limited to airports, railway stations near the border, and the seven-country border itself.

One of the most significant changes in the law, an amendment to the Drug Law of 1951 — last changed in 1981, is heavier sentences for producing, importing, exporting, or trafficking in narcotics. Sentences for these offences have been increased to up to 15 years (from up to five years), and "for aggravating circumstances, in particular if the act is carried out as a member of a gang," to up to 20 years (from up to 10 years).

The other side of the legislative coin is concern for the abuser. Those found in possession of small quantities of drugs are regarded as more in need of help than punishment. The 1981 amendment allowed the public prosecutor elbow room to postpone arraignment for two years, if the offender accepts medical treatment and the care and control of a social worker for the stipulated period.

The 1985 amendment removes the earlier requirement that medical personnel inform the police of patients with drug problems.

Another significant change relates to drug smuggling into Austria. As the law stood, convicted smugglers were sentenced on three counts — possession, dealing, and evasion of customs duties and taxes. Penalties on the last count often ran into hundreds of thousands of schillings, or long prison sentences. Smugglers will not now be charged under customs laws.

The new law comes into force in the wake of somewhat encouraging statistics in the 1984 report of the Austrian central narcotics department. The number of indictments of all offences — major and minor — under the narcotics laws has fallen below the 1982 total, following a modest rise in 1983.

The law does not discriminate between Austrians and foreigners. In 1984, 354 foreigners were convicted in Austrian courts, 46 more than in 1983. Of 44 countries represented the highest number (72) came from West Germany, followed by Switzerland (50), Turkey (35), and Iran (20). Egypt, India, Italy, Netherlands, Pakistan, and Yugoslavia were also in two figures. Eight were from the US, one from the USSR. There were no Canadians.

Austria's reputation as a transit country rests more on geography than on ease of passage for contraband carriers. The Austrian central narcotics department, set up just 12 years ago, has grown to be one of the largest units in the ministry of the interior, with 60 personnel.

There was a dramatic increase in the amounts of cocaine and heroin seized in the past two years: cocaine to 425 kilograms from 142 kg and heroin to 5,276 kg from 718 kg.

Liquor ad debate settles

AUCKLAND, NZ — Were there subliminal images of contorted human faces, eyes, dismembered body parts, floating skulls, and inverted masks in those liquor ads?

And, were they deliberately put there to induce recovered alcoholics back to drinking?

The answers are in, and they are not what New Zealand's Minister of Customs and Consumer Affairs Margaret Shields thought they'd be when she made those claims.

"They are hidden away in advertisements to operate at a subliminal level on the unconscious mind of reformed alcoholics to induce them back into consuming the product."

Keith Evans, the director of the government-appointed Alcoholic Liquor Advisory Council, called Ms Shields' remarks "unfortunate," and said there was no evidence of subliminal advertising in New Zealand.

But, one liquor company withdrew an advertisement it admitted contained an unmistakable penis image.

The liquor industry council's licensed beverage information committee took Ms Shields seriously, but came up empty-handed after investigating advertisements for four brands, "upside down and inside out."

To Ms Shields, the committee's fruitless study was "quite irresponsible" and ignored reputable research. So, she sought a professional view from a psychologist, a psychiatrist, and an independent advertising authority.

Now, the three-man subliminal advertising panel has completed its study. It did confirm, "to varying degrees," that it could discern the symbols pointed out to it.

"However," Ms Shields reported, "the panel found nothing suspicious or dubious in the advertisements."

Advertisement: New Zealand's minister of customs and consumer affairs saw distorted faces, floating bodies, and (far right) a phallic symbol 'hidden away to induce alcoholics back to drink'

NEWS

Van Mulligen: unexplainable

Drug store break-ins fluctuating

By Maureen Brosnahan

WINNIPEG — Drug store break-ins here declined dramatically in the last six months of 1984, but police and pharmacists say it may be a short reprieve.

Already, there have been 25 break-ins in Winnipeg alone in the first three months of 1985, and many have involved violence.

From June to December last year, there were 32 break and enters involving drug stores in Manitoba, compared to 61 in the previous six months. Most of them were in Winnipeg. As well, there were only seven armed robberies at the end of the year, compared to 13 at the beginning of the year.

Constable John Van Mulligen of the Royal Canadian Mounted Police's drug intelligence squad told **The Journal** he can't explain the decrease.

Rick Brown, director of the federal government's Bureau of Dangerous Drugs, said there could be several reasons.

"I think it's a combination of more of the crooks being in jail, and the pharmacists themselves have been putting in better security," he said.

But Mr Brown and Stewart Wilcox, registrar of the Manitoba Pharmaceutical Association, said numbers will be up again later this year, based on recent activities.

"I think they're starting to go up since the beginning of March," Mr Brown told **The Journal**. He cited a recent case in which a city drug store was the object of two robberies within a week.

"We really are concerned," Mr Wilcox said. "There has been a recent increase. We don't know if it's springtime or whatever." He added that some of the recent attacks have also involved violence.

In one case, a pharmacist was forced to lie face down on the floor, and one of the three robbers cut the back of his hand with a knife. When the pharmacist indicated the key to the narcotics cupboard was in the lab coat he was wearing, the robber ripped the pocket off with a knife.

Mr Wilcox said many addicts are turning to drug stores for pharmaceutical drugs because the illegal drug markets are drying up. But, he said, with desperate people, actions are not always calculated or rational. "That's our greatest fear. They aren't in control when they come in."

Mr Brown said the decline in break-ins has also resulted in a dramatic decline in the value of the drugs taken. In the first six months of last year, criminals made off with drugs valued at $316,564, compared to only $33,788 at the end of the year.

NEWS

System based on electronystagmography

Jury still out on test for multi-drug impairment

By Lynn Payer

NEW YORK CITY — A system said to provide highly accurate measurements of impairment caused by a variety of drugs of abuse is being marketed by a New Jersey company.

The ADMIT (Alcohol Drug Motorsensory Impairment Test) system is based on the electronystagmograph (ENG), which measures electrical potential around the eyes and is related to nystagmus, or rapid, involuntary oscillation of the eyeballs (**The Journal**, January).

Selig Solomon, president and chief executive officer of Pharmometrics, a division of the National Patent Development Corporation here, says evidence from the ADMIT system has stood up to two court tests in Monmouth County, NJ.

The company claims the system can detect alcohol, marijuana, cocaine, tranquillizers, amphetamines, barbiturates, opiates, hallucinogens, caffeine, aminophylline, dopamine, several gases, and approximately 75 combinations of drugs, with an overall accuracy greater than 95%.

But, researchers in related areas, while admitting they are unfamiliar with the ADMIT system, suspect that the degree of precision shown by these results will not hold up to further testing. While certain drugs undoubtedly do affect the ENG readings, they say, the results, while perhaps of statistical significance, are unlikely to be of diagnostic value.

Henry Murphree, MD, chairman, department of psychiatry, Rutgers University Medical School, Piscataway, New Jersey, told **The Journal** that it has been known since 1842 that nystagmus could be caused by drinking alcohol. Nystagmus was correlated with blood alcohol levels by French researchers as early as 1897.

"It is a pretty reliable indicator of alcohol intoxication," he said. But when he and co-workers used ENG to study hangover, "the kinds of records you get are highly qualitative. I would doubt great precision with the method."

Charles Shagass, MD, professor of psychiatry, Temple University Medical Center, Philadelphia, who studied ENG in the diagnosis of schizophrenia and effective disorders, told **The Journal** the method showed "a lot of effects that are statistically significant and can help in a vague, general way."

John French, chief of data analysis and epidemiology, alcohol, narcotics and drug abuse unit, NJ department of health, said: "I'm skeptical, because I haven't yet seen solid scientific or legal evidence for the system. But, that's not unusual at an early stage of development."

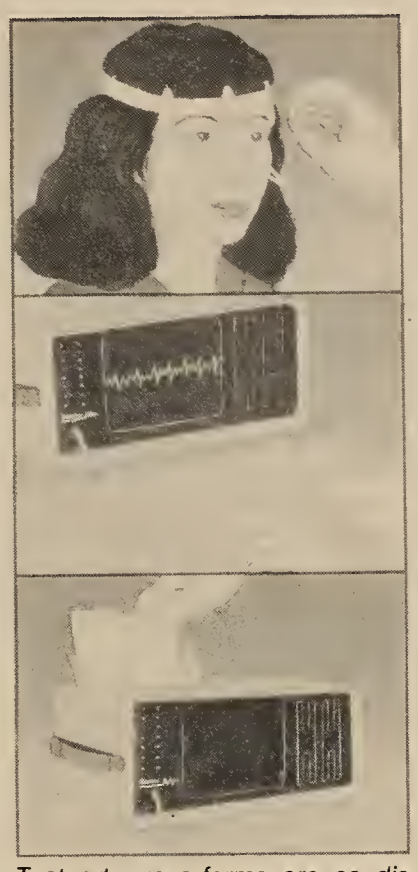
And Hugh Barber, MD, of Toronto, head of ENT, and professor of otolaryngology, University of Toronto, and author of the *Manual of Electronystagmography*, said after hearing the paper on which the ADMIT system is largely based: "I'm really from Toronto, but confess I'm also from Missouri on this business."

Electronystagmography was originally thought to measure the action potentials of the eye muscles and later the alterations in electrical potential between the cornea and retina produced by eye movement. But, it was found that readings could be made on anesthetized and, therefore, immobile eyes, suggesting that other electrical potentials were being measured. ENG is now thought to measure effects in the vestibular system, and is used by physicians to determine the cause of vertigo.

The ADMIT system is based on the work of Thomas Westerman, MD, a Schrewsbury, NJ, otolaryngologist and associate professor, Hahnemann Medical College, Philadelphia.

In a paper published in *The Laryngoscope* (Vol 94, No 2, Feb 1984), he reported drug-specific waveforms in 821 tests, including 248 double-blind tests in surgical candidates, healthy volunteers, and neonates.

According to this research, there were no false positives or negatives in analysis of waveforms produced by surgical candidates and healthy volunteers.



Test art: wave-forms are as distinct for each drug as fingerprints are for people, says ADMIT promotional material.

But, when Dr Westerman presented his results to the meeting of the Eastern Section of the American Laryngological, Rhinological and Otological Society in 1983, Dr Barber called for more information about impedance values, characteristics of the amplifier, frequency of the cut-off, and time constants. "We need other details — the test conditions, whether eyes were open or closed and, if closed, the nature of alerting effect, the calibration procedures, and so on," said Dr Barber.

He noted that some of the records published by Dr Westerman showed qualities that appear in normal individuals under varying conditions of mental alerting with eyes closed. The wandering baseline and square wave jerks attributed to opiates also occur frequently in over-alert or nervous people.

Noting that Dr Westerman reported no false positives or false negatives, Dr Barber commented: "Strip records of biological function are rarely — if ever — so distinctive, so decisive and clear that this remarkable confidence in their interpretation can be relied upon.

"What is needed is another study, preferably carried out in two or more places with careful experimental protocol arranged by a biostatistician, rigorous control of subjects and test conditions." Dr Barber added: "Until the results of such a research project are available, I believe the interesting ideas of Dr Westerman and his colleagues should be accepted with extreme caution."

Dr Barber told **The Journal** that he had had no reason to change his 1983 assessment.

Mr Solomon of Pharmometrics agreed that further trials were necessary and that they were working out a protocol for one with investigators at Johns Hopkins School of Medicine. The National Highway Traffic Safety Administration in Washington, DC, may also get involved in a laboratory and field study, says Ted Anderson, a research psychologist there, who would offer no other comment on the system.

The system is also being tested by the Monmouth County, NJ police. So far, said Mr Solomon, tests have been done on 2,500 people.

If the early results hold up, the system would offer several advantages over current methods to measure drug abuse in drivers. The system is non-invasive, and according to Dr Westerman, appears to measure level of impairment, which is preferable to measuring concentration, since individuals are impaired at different concentrations.

He pointed out that while blood-alcohol levels do not reach their maximum until approximately one hour after the end of drinking, the ENG may show specific changes within five minutes. And, unlike urine tests for marijuana, which may remain positive several days after the drug consumption, the ENG will show evidence for only about eight hours.

Allan Luks, executive director of the New York City Affiliate of the National Council on Alcoholism, told **The Journal** that there appeared to be a high level of interest in the system, particularly among companies.

Help for aprés drink vertigo?

NEW YORK CITY — A by-product of Thomas Westerman's electronystagmograph ENG research may be a method to reduce the vertigo that comes from lying down after having consumed large quantities of alcohol.

Dr Westerman noticed that several of the people who participated in his study (see related story) found, after drinking amounts of alcohol sufficient to cause "dizziness," that lying in a supine position, especially with the head to either side, would produce a significant degree of vertigo.

"It has been a common observation of these people that, if one foot is placed on the floor while lying in this position, vertigo is greatly reduced. This evidently produces a more stable spatial orientation. They appeared to be broadening their base in this action, which apparently aids their positional maintenance system, in addition to their vestibular end organ," Dr Westerman wrote in the September, 1981, issue of *The Largyngoscope*.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:

a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
¼ Page (280 lines) $250
c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation: 27,318 (Canada, 21,412; USA 1,907; Foreign, 386; Bulk, 3,613) Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount
Ontario residents billed as other Canadians.

The Journal, 33 Russell St
Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

This publication is indexed in
BIHEP
BIBLIOGRAPHIC INDEX OF HEALTH EDUCATION PERIODICALS

DEPARTMENTS

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Driving Under The Influence

Number: 652.
Subject heading: Impaired driving.
Details: 20 min, color.
Synopsis: Many people are killed or disabled in accidents caused by drinking drivers. People who have been affected tell about their feelings, and statistics are presented. Why is it happening? Other countries have harsher penalties for drinking drivers and foster attitudes less acceptable toward driving after drinking. In the United States, laws and attitudes are changing; perhaps the carnage will decrease.
General evaluation: Very good (5.1). This contemporary, well-produced film could lead to good discussion about impaired driving. Public broadcast was recommended.
Recommended use: With a resource person, this film could benefit audiences 15 years and older.

Dry Drunk Syndrome

Number: 653.
Subject heading: Treatment/rehabilitation.
Details: 30 min, color.
Synopsis: A husband accuses his wife of seeing another man and she, in turn, accuses him of drinking again. This argument, in a scene from a television program, is portrayed by three actors who have quit drinking in real life. Other scenes from the TV program show the man coming to work late and inappropriately dressed. Further arguments within the family erupt when he withdraws, refuses to get out of bed, etc — behavior patterns he had shown before he quit drinking. The actors step out of their roles to explain that these behaviors are commonly known as the "Dry Drunk Syndrome," a warning sign that help is needed to prevent a return to drinking. There is no end provided for the TV script; however, the actress playing the wife is shown exhibiting the Dry Drunk Syndrome in her real life.
General evaluation: Fair-good (3.7). While at times the interplay between the real characters was confusing, this film accurately depicts a common experience among recovering alcoholics. It was judged a good teaching aid. General broadcast was recommended.
Recommended use: With a resource person, this film could benefit families of alcoholics, health professionals, and those in treatment for alcoholism

For a Change

Number: 654.
Subject heading: Lifestyle.
Details: 25 min, color.
Synopsis: Most of us would like to change our behavior somewhat: exercise, give up smoking, go on a diet. This film outlines a method that can lead to change. Viewers are urged to become motivated, keep careful records of behaviors, identify "cues to action," set specific manageable objectives and rewards, and maintain the program. Concrete examples of people using this method illustrate ways of changing behavior by design.
General evaluation: Good-very good (4.8). This well-produced film was judged a good teaching aid about changing one's lifestyle. Public broadcast was recommended.
Recommended use: Could be used with ages 12 and up.

A Negative Cash Flow

Number: 656.
Subject heading: Attitudes and values.
Details: 7 min, color, animation.
synopsis: A man is urged to buy all his drinks from his wife. In this way, she will make a fortune and be able to forget him in comfort. After this tongue-in-cheek beginning, the real costs of drinking are illustrated, the obvious as well as the hidden costs. Viewers are urged to use the accompanying booklet to record what their drinking really costs them.
General evaluation: Very good (5.2). This humorous, animated film was judged a good teaching aid about the cost of drinking, even without using the booklet.
Recommended use: Of benefit to anyone who drinks.

ISSN 0228-863X
ISBN 0-88868-102-X

New Books

by RON HALL

Deterring the Drinking Driver: Legal Policy and Social Control

. . . by H. Lawrence Ross

For social scientists, this second edition is offered both as a review of what is known concerning the problem of drunk driving, and as a report on attempts to cope with the problematical behavior through law. It draws on the available evidence of the strengths and weaknesses of the paradigm, as a description and explanation of behavior subjected to legal control. The student of social science will find a possible model of how to investigate and present information on the state of knowledge in an important recurring problem in scientific work. The book is organized around specific predictions or hypothesis flowing from the deterrence proposition, which states that threatened behavior will be inhibited to the extent that punishment is perceived to be swift, certain, and severe. Experiences from many countries are brought together and analyzed. The author concludes that the main limitation of attempts to deter drunk driving lies in the failure of jurisdictions to raise the actual risk of punishment to a level that cannot be overlooked by potential violators.

(DC Heath Canada, Suite 1600, 100 Adelaide Street West, Toronto, Ontario M5H 1S9. 1984. 137p. $15.95. ISBN 0-669-08199-X)

Other Books

Guidelines for Investigating Alcohol Problems and Developing Appropriate Responses — Rootman, Irving, and Moser, Joy. World Health Organization, Geneva, 1984. Purpose of the guidelines; project formation; project planning; data collection; improving responses to alcohol problems; monitoring, assessment, and adjustment of policies and programs. 120p. World Health Organization, Geneva. ISBN 92-4-170081-5.

Directory of Canadian Transportation Safety Professionals — DeGenova, Katherine, and Blake, Catherine (eds). Addiction Research Foundation, Toronto. 1984. Alphabetical listing of transportation safety professionals, including a summary of demographic information, current research interests, and publications; indexed by geographical location, organization, and current research activities. 167p. Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell Street, Toronto, Ontario M5S 2S1. $8. ISBN 0-88868-099-6.

Drug Abuse Treatment Evaluation: Strategies, Progress, and Prospects — Tims, Frank M., and Ludford, Jacqueline P. (eds). United States National Institute on Drug Abuse, Rockville, 1984. NIDA Research Monograph 51; national treatment system; treatment outcome prospective study; clinical trials in drug treatment; outcome of narcotic addict treatment; psychotherapeutic approaches; clinical implications of drug abuse treatment outcome research. 180p. US Government Printing Office, Washington, DC 20402.

Evening Primrose Oil — Graham, Judy. Thorsons Publishers, New York, 1984. Description; botanical history; use in the treatment of medical conditions including alcoholism. 112p. Thorsons Publishers, 377 Park Avenue South, New York, NY 10016. $4.95. ISBN 0-7225-0743.

Alcohol: Preventing the Harm — Institute of Alcohol Studies, London, 1984. Papers presented at a conference; determinants of per capita consumption; social costs of alcohol use; community approaches to the problem of alcohol misuse; health education policies; politics of alcohol control. 90p. Institute of Alcohol Studies, Alliance House, 12 Claxton Street, London, SWIH OQS.

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

International Convention of Alcoholics Anonymous — July 4-7, Montreal, Quebec. Information: International Convention, Box 1985, Station D, Buffalo, New York 14210.

Management II for Supervisors in the Health Care Setting — July 5, Toronto, Ontario. Information: Professional and Management Development, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

26th Annual Institute on Addiction Studies — July 14-19, Hamilton, Ontario. Information: Kathryn Irwin, course administrator, Alcohol and Drug Concerns, Inc, 11 Progress Ave, Ste 200, Scarborough, ON M1P 4S7.

Summer School For Addiction Studies — July 15-26, Toronto, Ontario. Information: Doreen Ross, School For Addiction Studies, Addiction Research Foundation (ARF), 8 May St, Toronto, ON M4W 2Y1.

34th International Congress on Alcoholism and Drug Dependence — Aug 4-10, Calgary, Alberta. Information: Jan Skirrow, chairman, 34th ICAA Congress, AADAC, 6th floor, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

Canadian Addictions Foundation Annual General Meeting — Aug 5, Calgary, Alberta. Information: Leona Gallinger, Canadian Addictions Foundation, Pacific Plaza, Box 702, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

23rd Annual Summer Conference of the International Transactional Analysis Association (ITAA) — Aug 8-11, Toronto, Ontario. Information: Dale Perrin, 2055 Dundas St E, Ste 104, Mississauga, ON L4X 1M2.

10th International Congress of Hypnosis and Psychosomatic Medicine, Introductory and Specialized Workshops and Scientific Program — Aug 10-16, Toronto, Ontario. Information: 10th International Congress Secretariat, 200 St Clair Ave W, Ste 402, Toronto, ON M4V 1R1.

2nd International Conference on Illness Behavior — Aug 14-16, Toronto, Ontario. Information: IBC, c/o Gut Behaviour Unit, Toronto Western Hospital, 399 Bathurst St, Toronto, ON M5T 2S8.

Royal College of Physicians and Surgeons of Canada — 54th annual meeting — Sept 9-12, Vancouver, British Columbia. Information: Robert A. Davis, coordinator, Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

The Canadian Thoracic Society and the Medical Section of the Canadian Lung Association, conjointly with the Royal College of Physicians and Surgeons — Sept 9-12, Vancouver, British Columbia. Information: A. Les McDonald, health education coordinator, Canadian Lung Association, 75 Albert St, Ste 908, Ottawa, ON K1P 5E7.

Annual Meeting of the Canadian Society of Forensic Science — Sept 20-27, Montreal, Quebec. Information: executive secretary, Canadian Society of Forensic Science, 2660 Southvale Cres, Ste 215, Ottawa, Ontario K1B 4W5.

Ontario Public Health Association 36th Annual Educational and Scientific Meeting — Sept 22-25, Toronto, Ontario. Information: Ontario Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, ON K1Z 8N8.

What an Employer Needs to Know to Make an Effective Intervention — Oct 2-4, Toronto, Ontario. Information: Yvonne Johns, intervention services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Productivity 85 (EAP) — Oct 23-24, Saskatoon, Saskatchewan. Information: Personnel Performance Consultants, Box 7811, Saskatoon, SK S7K 4R5.

Input 85 — The 6th Biennial Canadian Conference on Employee Assistance Programs in the Workplace — Oct 27-30, Ottawa, Ontario. Information: Input 85 Headquarters, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Northern Youth in Crisis: A Challenge For Justice — Nov 3-8, Val d'Or, Quebec. Information: Northern Conference Office, c/o Continuing Studies, Simon Fraser University, Burnaby, British Columbia V5A 1S6.

1985 Ontario Occupational Health Nurses Association Conference — Nov 4-8, Toronto, Ontario. Information: B.J. Varey, RN, CCOHN, publicity committee chairperson, c/o Sun Life of Canada, 3rd fl, 150 King St W, Toronto, ON M5H 1J9.

Skill Training for Employee Assistance Personnel — Nov 17-21, Oakville, Ontario. Information: James Simon, Peel Centre, ARF, 39 Dundas St E, Ste 203, Mississauga, ON L5A 1V9.

23rd Annual Scientific and Business Meeting — Nov 27-30, Toronto, Ontario. Information: Ontario Chapter College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

Symposium 86: Focus on the Family — Jan, 1986, Toronto, Ontario. Information: Gilda Ennis, Metatron, 53 Lisa Cres, Thornhill, ON L4J 2N2.

International Association of Forensic Sciences 11th Meeting — Aug 2-7, 1987, Vancouver, British Columbia. Information: International Association of Forensic Sciences, 801-750 Jervis St, Vancouver, BC V6E 2A9.

United States

14th Annual San Diego Summer Alcohol and Drug Studies Program — July 8-12, La Jolla, California. Information: P.A. Moore, UCSD Extension, X-001, La Jolla, CA 92093.

Managing Employee Assistance Programs July 10-11, Center City, Minnesota. Information: Linda Hutchinson, Hazelden, Box 11, Pleasant Valley Rd, Center City, MN 55012.

3rd Annual Chemical Dependency and Family Intimacy Summer Institute — July 14-19, Marine-on-St Croix, Minnesota. Information: Diane Campbell, Program in Human Sexuality, 2630 University Ave SE, University of Minnesota, Minneapolis, MN 55414.

17th Annual Nevada School of Alcohol and Drug Abuse — July 15-19, Reno/Sparks, Nevada. Information Bureau of Alcohol and Drug Abuse, 505 E King St, Rm 500, Carson City, NV 89710.

Developing Employee Assistance Programs — July 24-26, Seattle, Washington. Information: Linda Hutchinson, Hazelden, Box 11, Pleasant Valley Rd, Center City, MN 55012.

New Jersey Summer School of Alcohol and Drug Studies — July 28-Aug 2, Piscataway, New Jersey. Information: Gail Milgram, Education and Training Division, The State University of New Jersey Rutgers, Center of Alcohol Studies, Smithers Hall, Piscataway, NJ 08854.

Chemical Dependency and the Older Adult: Challenge of the 90s — Aug 1-2, St Paul, Minnesota. Information: Hazelden, Box 11, Pleasant Valley Rd, Center City, MN 55012.

1985 DUI Awareness Institute — Aug 2-3, Chicago, Illinois. Information: Kay Zlogar, director of special projects, 120 W Huron St, Chicago, IL 60610.

36th annual conference of the Alcohol and Drug Problems Association of North America — Confronting the Issues — Challenges for the 80s — Aug-18-21, Washington, DC. Information: Eric Scharf, ADPA, 444 N Capitol St, Ste 181, Washington, DC 20001.

Family Institute — Aug 26-30, Center City, Minnesota. Information: Hazelden, Box 11, Pleasant Valley Rd, Center City, MN 55012.

North American Congress on Employee Assistance Programs — Aug 26-30, St Louis, Missouri. Information: Diane Vella, congress coordinator, NAC/EAP, 2145 Crooks Rd, Ste 103, Troy, Michigan, 48084.

9th World Conference of Therapeutic Communities — Sept 1-6, San Francisco, California. Information: Walden House Inc, 815 Buena Vista W, San Francisco, CA 94177.

Adolescent and Family Treatment: An Investment for the Future — Sept 18-20, San Diego, California. Information: Nomi Feldman, conference coordinator, 370 Tansy, San Diego, CA 92121.

1st National Association of Lesbian and Gay Alcoholism Professionals Conference — Sept 26-29, Chicago, Illinois. Information: NALGAP, 1208 East State Blvd, Fort Wayne, Indiana 46805.

International Youth Services Conference — Oct 6-9, Chicago, Illinois. Information: Bill Treanor, executive director, American Youth Work Center, 1346 Connecticut Avenue NW, Ste 925, Washington, DC 20036.

Clinical Dilemmas in a Period of Change — Oct 9, Boston, Massachusetts. Information: Elizabeth Chichak, RN, New England Memorial Hospital, Five Woodland Rd, Stoneham, MA 02180.

National Federation of Parents for Drug-Free Youth, 4th annual conference — Nov 6-9, Washington, DC. Information: Mary Jo Green, NFP, 1820 Franwall Ave, Ste 16, Silver Spring, Maryland 20902.

Association of Labor Management Administrators and Consultants on Alcoholism, 14th Annual Conference — Nov 10-14, Boston, Massachusetts. Information: Judith Evans, associate director, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

Association for Medical Education and Research in Substance Abuse, 9th Annual Conference — Nov 14-15, Washington, DC. Information: Dr G. Lewis, AMERSA president, Center for Alcohol Studies, Brown University, Box G, Providence, Rhode Island 02912.

10th Annual Southeastern Conference of Alcohol and Drug Abuse (SECAD 10) — Dec 4-8, Atlanta, Georgia. Information: Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, GA 30342.

Abroad

International Youth Forum on Alcohol and Drugs — July 9-12, Cardiff, United Kingdom. Information: Dr Myrddin Evans, Addiction Unit, South Glamorgan Health Authority, Whitchurch Hospital, Whitchurch, Cardiff, CF4 7XB, United Kingdom.

1985 World Congress on Mental Health — July 14-19, Brighton, England. Information: Barbara Poole, world congress organizer, 22 Harley St, London, England W1N 2ED.

15th Biennial Caribbean Federation For Mental Health Conference — July 21-26, New Providence, Bahamas. Information: The Bahamas Mental Health Association, PO Box N-7531, Nassau, Bahamas.

3rd International Conference on Alcohol and Drug Abuse — Aug 11-14, Lima, Peru. Information: L. Vasquez, MD, International Education, Peruvian College of Physicians, Wadsworth, IL 60083.

2nd National Drug Institute — Alcohol and Drug Use in a Changing Society — Aug 14-16, Darwin, Northern Territory, Australia. Information: Chairman, NDI Planning Committee, Drug and Alcohol Bureau, Northern Territory department of health, GPO Box 1701, Darwin NT 5794 Australia.

12th World Conference on Health Education — Sept 1-6, Dublin, Ireland. Information: Mary D'Ardis, conference coordinator, 12th World Conference on Health Education, 34 Upper Mount St, Dublin 2, Ireland.

European Congress on Prevention of Alcoholism and Other Drug Dependencies — Sept 30-Oct 4, Opatija, Yugoslavia. Information: International Commission for the Prevention of Alcoholism and Drug Dependencies, Non-governmental Organization of the United Nations, 6330 Laurel St, NW, Washington, DC 20012.

International Congress on Local Authorities and Drug Policy — Oct 23-24, The Hague, The Netherlands. Information: Municipality of The Hague, Dr N. G. Geerts, MWV, PO Box 80.000, 2508 GA The Hague, The Netherlands.

'I will be loyal to the profession of medicine, and just and generous to its members'

from the Hippocratic Oath

Some of his colleagues 'fail the test'

A physician recalls an ancient promise

By Tim Padmore

VANCOUVER — Ken Varnam is a big, solid man, whose voice and presence fill his little office without the need for gesture and movement.

But now his indignation propels him from his chair. He strides to a framed reproduction of the Hippocratic oath on the wall by the door.

"Here, this is the part: '. . . I will be loyal to the profession of medicine and just and generous to its members.' " The events of the past year have put the oath to the test, and many of his colleagues have, in his eyes, failed.

The test was a series of charges (of trafficking in and improperly administering a number of controlled drugs) laid against Dr Varnam and six other doctors in May, 1984 (**The Journal**, July 1984).

Since then, all the charges against the doctors have either been dismissed or stayed, following landmark court decisions that have largely supported doctors' rights to follow their best instinets in prescribing treatment.

But the stigma of the charges lingers.

At the point of opprobrium was Dr Varnam, the most prominent of those charged, a director of the British Columbia Medical Association (BCMA), and chairman of the association's drug abuse committee.

In an exclusive interview with **The Journal**, the Vancouver family physician said the reaction to the charges shocked him, but that he has no regrets about the decisions that led him three decades ago to make treatment of drug addiction a major part of his practice.

"I went into medicine because I was interested in why people behave the way they do."

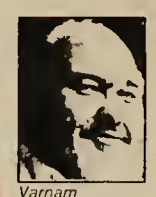
He studied and interned at Vancouver General Hospital, but was deflected from his aim of specializing in psychiatry by his experience in a one-year family practice locum.

"In family practice, you see people with a full spectrum of behavior, and you see how people react to diseases of all kinds," he said. "In psychiatry, you see people who have been screened by someone else."

His first addicted patient was a man who had been drinking heavily and had stuffed a mickey in his back pocket. When a passing car caused him to stagger backward and fall, the bottle broke, gashing his buttock. In hospital, where Dr Varnam sutured the injury, the man went into opiate withdrawal.

The man, it emerged, was consumed with guilt over a fatal auto accident, had started drinking, and then turned to heroin.

A few other addict-patients turned up and, said Dr Varnam, he found their oddities fascinating. For two years, he said, he deliberately avoided reading the literature, so he could make "unbiased" observations.



Varnam

Seven BC doctors face drug pro

By Tim Padmore

VANCOUVER — One of seven doctors charged here with trafficking in addictive drugs is a director of the British Columbia Medical Association (BCMA) and chairman of the association's drug dependency committee.

Kenneth Varnam and six other physicians were charged in May after a police undercover op- tion that began in November and ended in January.

Separate trial dates for the se doctors charged — Dr Varnam Drs Robert Schulze, Antho Read, Anthony Otto, Gabriel Yon Charles Chow Tai and Carlos Gu man — have been set between Au

charged, to the College of Physicians and Surgeons of BC.

A College spokesman told The Journal the College has not been re- ig

Vancouver MD to stand tr on controlled drug charg

By Tim Padmore

idence, including Dr Varnam's re- ply that Ritalin is tightly restricted but that he would be willing to give him Tenuate instead.

"I'll give you a prescription for nothing which is probably the — or next best — to ing that's

pharmacies so that prescription orders can instantly be checked against records in other pharmacies;

• government-run or -funded clin- ics to treat all drug dep- ple in a

ment agencies a cians; and,

• physician sup- donations.

Mr Simons said Dr V dogmatically citing th ommendations for u and that it is up to t tors to decide whet drug is required for He also argued t tion did not con ing."

ever, Jud

Court rules that prescribing is not trafficking

Charges dropped against BC d(

By Tim Padmore

VANCOUVER — A second court decision has further weakened the cases against seven doctors charged in May 1984 with a variety of drug trafficking offences (The Journal Nov July 1984).

Last December, a provincial court judge declared null a charge of "being a practitioner unlawfully administering a controlled drug" against Dr Anthony Otto.

Earlier the Saskatchewan Court of Appeal, overturning a lower court decision, ruled that prescribing does not constitute trafficking under the Narcotic Control Act.

Following the Saskatchewan decision, the Crown stayed all the trafficking charges that had been laid against the British Columbia doctors under that Act.

However, other charges had been laid under the Food and Drugs Act. (Different drugs are covered under different Acts. For example, Talwin [pentazocine] is a controlled drug under the Food and Drugs Act, while Fiorinal C [ASA, codeine, caffeine, butalbital] is defined as a narcotic under the Narcotic Control Act.)

The Crown also stayed charges of trafficking laid under the Food and Drugs Act. However, that Act also provides for regulations that define as an offence the "administration" of a drug not required for treatment to someone not a pa tient.

The December tively dismisse charges laid aga the act.

Judge Robert I the offence was law."

As The Journa only two doctor mitted for trial administering ch committed for tr est court decisio

Headlines: but doctor has "no regrets" about decision to treat addict-patients

"I'm glad I did that," he says now, pointing to condemnatory "moral judgements" that can still be found, but which were common in the 1950s.

He tried LSD as a therapy until about 1962, with "a couple of successes," but switched to methadone maintenance when it came in as treatment modality.

His caseload of addict-patients mushroomed in 1978 when the province introduced the controversial Heroin Treatment Act, which provided for compulsory withdrawal, along with a policy against accepting new patients for methadone maintenance.

With up to 50 addict-patients, it was no longer possible to "hide" the addicts among his regular patients, and he started a morning clinic — something he is still in doctor would give him a Ritalin prescription.

Dr Varnam gave the man, later identified as police Constable Kenneth Cardinal, a prescription for Tenuate (diethylpropion). Their conversation was recorded by a tape machine carried by Const Cardinal. Similar undercover operations were carried out at other doctors' offices.

One of the first calls Dr Varnam got after the charges were laid was from BCMA president Duncan McPherson, MD, who asked him to resign from the board and from his committees.

He refused, despite what he calls a general lack of support from the board. There was also an unsuccessful attempt at a closed session of the association's general meeting to bar any doctor charged with a crime from holding a BCMA office.

"I lost probably 10% to 20% of my practice at the time," said Dr Varnam, "although I've rebuilt some of it now." The patients just "quietly disappeared," although many of those who stayed voiced support.

At Shaughnessy Hospital, where he admits the most patients, the atmosphere remained friendly, but there was "a slight iciness" elsewhere that has not yet entirely melted.

Ironically, Dr Varnam never got his day in court to answer police testimony entered in a pre-trial hearing. Because of the stay of proceedings, his trial, which was scheduled to be under way the day he spoke to **The Journal**, never took place.

What would he have told the court?

"The police feel if you present a picture where the person is a prostitute, on the edge of society, then you wouldn't even consider doing anything about them. But the ethics of medicine say you should treat *anyone*."

The history the undercover agent gave was plausible, he said, and giving the patient a drug to help him stay awake was justified medically because it would relieve stress that could lead to illness.

And, he tried to maintain some control to counter the evident potential for abuse. "He asked for Ritalin. I refused. He asked for diazepam (Valium). I ignored that."

Instead, he prescribed Tenuate, in a form which Dr Varnam said is difficult to abuse, because the active component is difficult to extract. He said he advised the patient against taking more than two a day because the drug can cause anxiety and other adverse reactions.

The matter of control, said Dr Varnam, is the essence of treatment.

"You have to have a control of the person, whether you give them what they ask for, whether you try them on something else, or whether you just say no."

The goal of therapy, he said, is "to have someone function in society without being a hazard to themselves or to society."

He said he recognizes that narcotic use is one way of dealing with genuine problems.

Dr Varnam continues to try to unravel the connection. For example, he has found that 40% of his narcotic-addicted patients have histories as "presumptive hyperactive" children, and he is now working to extend the research to include other BC doctors with addict caseloads.

"I think I've learned a lot about people. To a large extent, I have fulfilled my aim in going into medicine. I can now begin to analyze why people have this (addictive) behavior.

"And, another thing," he added with a note of pride, "there are damned few people willing to look at these people."

THE BACK PAGE

Church leaders of three nations discuss addictions p7

"Fifty Years with Gratitude" International AA Convention p5

A week in the life of the AADAC centre section

Make the most of you. AADAC

Vol. 14 No. 8 2nd Class Mail Reg No. 2776 TORONTO August 1, 1985

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

THC okay for cancer treatment

WASHINGTON — An analogue of delta-9-tetrahydrocannabinol (THC) has been approved by the US Food and Drug Administration for treating nausea and vomiting in cancer patients receiving chemotherapy.

Approval by the agency follows extensive testing at medi-

(See Free — p2)

Money, equipment wanted to fight drugs from abroad

US to step up anti-trafficking efforts

By Harvey McConnell

WASHINGTON — The Reagan administration, Congress, and United States military leaders are all pushing for more money and power to fight drug trafficking from abroad.

Attorney General Edwin Meese has announced that the administration is seeking an additional US$101.6 million (Cdn $137 million) from Congress, to help "shake the foundations of deeply-entrenched and sophisticated drug empires."

The annual budget for anti-drug enforcement is now US$1.2 billion (Cdn $1.6 billion). The new fund will include US$26.8 million additionally for the US customs service, and would be used for planes and boats equipped with sophisticated detection equipment. Another US$25 million will go to the coast guard, US$20 million to the drug enforcement administration, and the rest to other agencies involved in the anti-drug fight.

The attorney general said the US has major efforts going on all over the world, and there is no country that is a source of drugs, which "is not co-operating to some extent. We are keeping pressure on these countries."

Both the House of Representatives and the Senate have approved additional powers for the US military to allow offshore interception of drug traffickers.

Sixteen military surplus planes will be equipped with highly-efficient radar to intercept planes and boats trying to run drugs into the continental US. At least two of the planes will be stationed in Panama.

Under the plan, the planes will be flown by US Air Force reserve officers, and their intelligence information will be passed on to the US customs and coast guard services.

It is also reported that the joint chiefs of staff have recommended to the administration that the US military help train, in any country

(See DEA — p2)

Meese: 'keeping the pressure on'

Jeppe: in Finnish or in English, information message is appropriate

Alko messenger is no toy

HELSINKI — A plastic figure named Jeppe is carrying the Finnish State Alcohol Company's (Alko) message about the effects of alcohol to the public.

"*Mina olen Jeppe, Alkon juopotteleva nukke. Anna minulle juotavaa,*" Jeppe says through a computerized voice synthesizer. "My name is Jeppe, Alko's drinking model. Give me a drink."

For Jeppe, alcohol is represented by ball bearings; viewers raise a shot glass of them to his lips and the ball bearings roll down his throat to various organs. There, they trigger detectors, illuminating signs that tell the effects of alcohol on those organs.

When the simulated alcohol reaches Jeppe's brain, he becomes much more talkative. What he says is determined by his "alcohol" concentration, which is displayed on a plastic cylinder.

Sometimes Jeppe asks the viewer to type in his or her name, and, since Finnish is pronounced the same as it is written, he is able to carry on a personalized conversation. After he has a bit more to drink, he occasionally tries to speak English.

Jeppe (pronounced Yep-pe) is the brainchild of John David Sinclair, PhD, of Alko's research laboratories. "Jeppe was so successful at the Pulssi exhibit (a medical exhibition), we are considering an English version," Mr Sinclair says. "Our information department plans to use him in an educational film."

The information Jeppe provides is balanced, including both negative and positive consequences of alcohol consumption. Alko distributes similar information in other ways, but the company finds Jeppe effective because of his entertainment value, especially with young people.

Bermuda premier backs formation of national alcohol and drug agency

By Joan Hollobon

TORONTO — The major organizational recommendation of the Bermuda Royal Commission into the Use and Misuse of Illicit Drugs and Alcohol is the establishment of a new and permanent National Alcohol and Drug Agency (NADA), responsible directly to the Premier's Office.

Commissioner H. David Archibald, who is also president of the International Council on Alcohol and Addictions, considers such an organization essential to provide leadership and overall direction.

Bermuda has a number of excellent programs, but lacks an overall strategy for communication and collaboration between agencies, whose "dominant theme" is "protect your own turf," the Commission's final report says.

A special report on education and training provided evidence of widespread use of alcohol and drugs throughout the Bermuda school system. Of those who use alcohol, 26% began at age 10 or less. The frequency of drug use varied substantially between schools, but "no school was without a problem."

Detailed recommendations were aimed at developing educational and counselling programs designed to "prevent, reduce, and/or stabilize" drug use, and aid students with problems. The plans included teacher training, and development of research and evaluation tools.

Concomitantly, public education programs would seek to change public and parental attitudes, since a school program "is less likely to succeed if the attitude and knowledge level of the general public, in particular, parents, remain unchanged."

The special report on the justice system analyzed first the impact of international drug trafficking, and second, the effects of Bermuda's internal justice system.

Recommendations on the first were aimed at keeping drugs out of Bermuda by improved surveillance, collaboration between the detection and investigation branches (customs and police), and severe crackdowns on major traffickers and those who finance them.

Recommendations on the second sought to "reduce the very severe

(See Bermuda — p2)

Bermuda Mosaic — Back Page

Bermuda Premier John Swan, in a public speech, endorsed the need for the NADA, which he sees as "a catalyst for action."

The Commission's work resulted in five special reports on specific aspects of the situation, plus a final summary report including an addendum, *The Bermuda Mosaic*, which analyzed Bermuda's social fabric.

INSIDE

NEWS

Briefly...

Smoking and fertility

CHICAGO — Smoking may impair fertility, say researchers at the United States National Institute of Environmental Health here. A study of 678 women indicated that those who smoked had only 72% of the "per-cycle" pregnancy rate of non-smokers. The effect was most pronounced among heavy smokers, said the researchers in a report in *The Toronto Star*. Meanwhile, smokers who avoid pregnancy by using oral contraceptives have 23 times the risk of heart attack than non-smokers, says *The Star* about another study from Boston University and the University of Pennsylvania.

Bartender support

NEW YORK — Most United States citizens back harsh penalties for drunk driving, but 72% of 1,402 people polled here believe that bartenders and social hosts should not be held responsible for alcohol-related accidents. *Associated Press* reports that in 35 US states, bartenders can be sued for damages caused by inebriated patrons. And, in New Jersey, social hosts may be held liable for drunk-driving accidents caused by their intoxicated guests.

Sour grapes?

BURLINGAME, Cal — Wine growers here are furious at Seagram liquor advertisements which equate a glass of wine with a shot of liquor. The Winegrowers of California, in a press release, claim that wine is recognized as the beverage of "moderation and good taste." They argue that wine is a food, is natural, contains many nutrients, is a part of religious ceremonies, and "plays an important and useful medical role," for its "mild, tranquillizing effect, aid to digestion, as an appetite stimulant, and use in the treatment of certain cardiovascular and gastroenterological diseases."

Beer should tell all

NEW YORK — The United States National Council on Alcoholism (NCA) has called on the federal government to require full disclosure of alcohol content on beer containers. Mention of alcohol content is currently prohibited by the federal Bureau of Alcohol, Tobacco and Firearms. The NCA's call stems from concern over increased availability of "non-alcoholic" and "de-alcoholized" beers, which, they say, contain as much as 0.5% alcohol. The beers are a health risk, says the NCA in a press release, to recovering alcoholics, minors, pregnant women, and women considering conception.

Up prices, down ads

LONDON — The UK government should increase the price of alcohol significantly, and should cut liquor advertising, say Scottish family doctors. They say that, in real terms, the price of alcohol has halved in recent years. The doctors state that direct and "insidious" advertising should be cut. Smoking, they say in an article in *Doctor*, is now giving way to drinking on television programs.

New group targets abuses

By Harvey McConnell

WASHINGTON — A half a million signatures by the end of 1985, on its declaration of independence from alcohol and drug abuse in the United States is the aim of the newly formed Americans for Substance Abuse Prevention (ASAP).

Edward Carels, PhD, president of the Care Institute, Newport Beach, California, and an ASAP founder, said if the issues of substance abuse are "ever to be dealt with practically," it must be with pressure by the voters.

He told a large audience at a ASAP declaration of independence from alcohol and drug abuse ceremony here, "we are hoping to start a grassroots, constituency organization that tries to make something happen, and by the end of the year, we hope to have 500,000 signatures on a petition calling for action on alcohol and drug issues."

He emphasized that ASAP is a voluntary, non-profit, and non-partisan organization. The movement might be likened to "a Sierra club of the mind and body," for US citizens concerned about "pollution of people's mind and bodies with chemicals."

George Gallup Jr, chairman of ASAP and head of the Gallup organization, told the meeting that Gallup polls have shown 81% of people in the US feel alcohol and drug abuse is a major, national problem, and something should be done about it.

And, one of the ironies of US psychiatry is that while people "desperately want trim, strong, healthy bodies, and are willing to agonize through whatever exercise and diet programs deemed necessary to reach that goal," little headway is being made in patterning habits destructive of health, such as alcohol and drug abuse.

Mr Gallup said telephone calls for the Care organization found that one third of those questioned said drinking had been a cause of trouble in their families. On the other hand, only 45% of those who had serious problems with drinking had sought help, another poll found.

There is no demand for a return to prohibition in the US: only 17% of those questioned said there should be a ban on the sale of wine, beer, and spirits, the lowest such figure recorded by the organization in 50 years.

Joseph Califano, secretary of health, education, and welfare under Jimmy Carter, and a prominent Washington lawyer, said that if there is no aggressive move in research, prevention, and treatment, alcoholism will be the number one disease as the US enters the twenty-first century.

He called for establishment of a National Institute of Addictions, under the umbrella of the National Institute of Health, which would focus research on all addictions: cigarettes, heroin, cocaine, marijuana, all drugs licit and illicit.

"Alcohol and drug abuse are not irresistible forces," and every one can do something, Mr Califano added.

"It is up to adults to use their freedom to wage a saturation campaign against addiction. If we don't, we are forcing our children to walk through a terrifying minefield, drug abuse and addiction, on their way to adulthood."

Pollin retires

WASHINGTON — A new director is being sought for the National Institute on Drug Abuse(NIDA), following the resignation of William Pollin, MD, after six years.

Dr Pollin, who started his government career with the National Institute of Mental Health in 1956, is retiring from the commission officer corps of the US public health service. It is understood his resignation has been made for purely personal reasons.

Dr Pollin succeeded Robert Dupont as NIDA director in 1979. Jerome Jaffe, MD, director of the NIDA Addiction Research Center, has been appointed acting director.

Pollin: for personal reasons

Bermuda given blueprint for action

(from page 1)

negative impact of criminalization" for those convicted of possession of small amounts of cannabis. The government should assign to the customs service "a much higher priority for the search and detection of illicit drugs," providing more training and equipment for customs officers, including a drug-sniffing dog.

A review of Bermuda's police and customs services should be conducted to determine the best collaborative approach.

Severe penalties were advocated for major traffickers.

The Commission found no evidence of control of the police by criminal organizations, or of any "significant money laundering," or that Bermuda has "one single Mafia-type vice-president."

However, a number of smaller "drug syndicates" exist, "with approximately 35 key individuals making a substantial profit through the importation and trafficking of illicit drugs."

The Commission called for greater emphasis on forfeiture of possessions and assets acquired from importation and trafficking, directed at major traffickers, not at "the street pusher, or the couriers of small amounts of drugs."

The maximum penalty for those importing and trafficking in large amounts of cannabis should be increased to a life sentence without parole.

Mr Archibald, founder and retired director of the Addiction Research Foundation of Ontario here, told The Journal that his work in Bermuda had led him to examine seriously the magnitude of international drug trafficking.

"I don't think we are going to be able to make a serious impact on the drug scene until internationally, we get a handle on this business of trafficking," he said.

Cannabis is the illegal drug most widely used in Bermuda, but legalization is not an option: the best approach, the Commission suggested, would be "by policy (as opposed to legislation), to ensure that no more Bermudians are sent to prison for possession of small amounts of cannabis (eg, less than three grams) for personal use."

The report also advocated a review of the jury system, sentencing policies, and police powers and community relations.

Trial by jury is so fundamental to a free society that Mr Archibald was reluctant to accept suggestions made to the Commission for its abolition. He also believes that reluctance of juries at times to register a conviction reflects their unwillingness to see defendants go to prison for possession, rather than community tolerance of drug abuse.

The special report on alcohol and its impact on Bermuda, notes evidence for a direct association between overall levels of consumption in a population and the prevalence of alcohol-related problems.

The special report on treatment and rehabilitation gave a high priority to the development of employee assistance programs. The government moved rapidly on this: a committee had been struck and discussions with the business community were already underway by mid-June.

Development of a driving-while-impaired program for compulsory driver education and treatment was recommended.

Drug treatment programs, including methadone maintenance, halfway houses, and rehabilitation centres should be expanded or established as required, with close collaboration among agencies.

Urging acceptance of the recommendations as a "blueprint for action" with an immediate start on implementation, the report concluded: "It is the considered opinion of this Royal Commission that Bermuda can be successful in reducing to a tolerable level the problems associated with alcohol and drug use and abuse."

THE JOURNAL
— next month —
World Congress on Mental Health

DEA training at FBI

(from page 1)

which requests it, fast-moving teams to attack production of illicit drug crops. The teams, to be recruited locally from the country concerned, would be given, or loaned, equipment from the US military.

In the meantime, the Drug Enforcement Administration (DEA) more and more is becoming effectively part of the Federal Bureau of Investigation (FBI). From 1986, training of DEA agents will take place at the FBI Academy in Quantico, Virginia. At present, DEA agents are trained at a government facility in Georgia, which also trains agents for 50 other federal agencies.

Attorney General Meese, in announcing the move, said "the special bond" between the DEA and the FBI dictates training agents at a common site. The first steps in the merger were taken by the administration in 1981, when the DEA was ordered to report to the justice department through the FBI.

Since 1981, top FBI men, first Francis Mullen, and now John Lawn, have been made DEA administrators. Mr. Lawn said the DEA staff training will enhance the until-now, limited expertise of the FBI in the drug trafficking field.

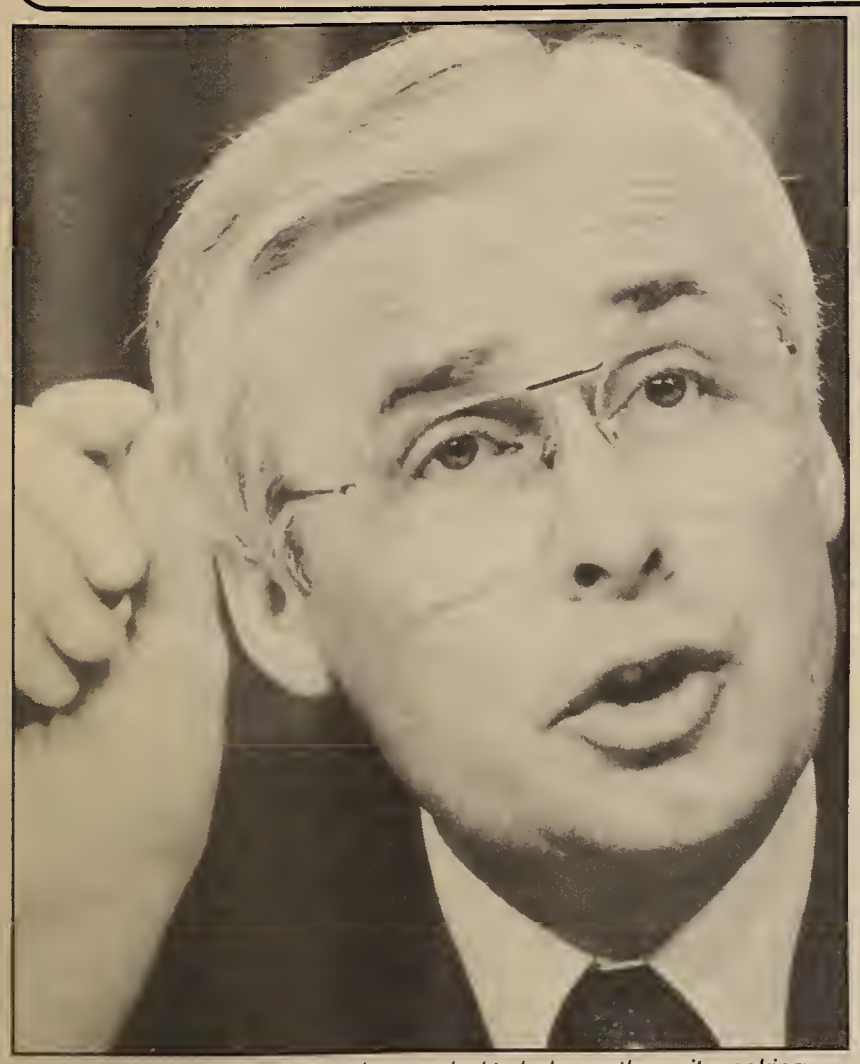
Free THC from NCI is cut

(from page 1)

cal centres around the country; the drug has been available for cancer patients, through the National Cancer Institute (NCI), for the past five years. The free NCI-THC supplies will cease with commercial production

Patients will be able to obtain prescriptions for THC through doctors licensed by the Drug Enforcement Administration to dispense scheduled drugs. Currently, THC is under schedule 1 (drugs with abuse potential, which have no accepted medical value), and will be moved to schedule 2 (drugs of potential abuse, but with accepted medical use). The gelatin capsules containing the THC are not thought to have an abuse potential.

NEWS



Epp: 'big brother' stance may be needed to help youths quit smoking

Feds new anti-smoking action will involve volunteer groups

By Rhonda Birenbaum

OTTAWA — Governments should be doing more to keep young Canadians from smoking, even if it means adopting a "big brother" stance, Minister of Health and Welfare Jake Epp says.

"Program efforts to promote non-smoking have been insignificant at inducing behavioral changes in young people," he told a Canadian Lung Association meeting here.

"We can do better than we have done, and I'm willing to risk being called 'big brother' to do that."

Mr Epp announced plans for a new national program to decrease smoking by young people. He later told **The Journal** the program will be based on government collaboration, both federal and provincial, with non-governmental organizations, especially volunteer groups.

"The ministry does not have a good history of collaborating with non-government organizations," Mr Epp said, a situation he would like to see changed.

The health ministry has asked the Canadian Lung Association, the Canadian Cancer Society, the Canadian Heart Foundation, the Canadian Council on Smoking and Health, the Canadian Public Health Association, the Canadian Medical Association, and the Toronto-based Non-Smokers' Rights Association, to participate.

None of the volunteer groups is committed to the program yet, but representatives have been asked to meet with federal ministry staff and representatives of the provincial ministries.

The federal ministry plans a fall launch for the new program, after the planning group defines what will be done, and identifies target groups and projects.

Initially, the national program will focus on youth, with a more direct, aggressive message than is used currently. Paul Melia, acting chief of tobacco programs in the health promotion directorate, says the current campaign has not been as effective as expected, probably because of its close link to the federal government.

"Bringing together a mix of government and non-government organizations should be a benefit to all," he told **The Journal**. Private organizations are better able to take information to target groups, for example, while the government can develop a national advertising campaign.

Mr Melia said a national clearinghouse on smoking and health is being considered to identify existing information and act as a central distribution point. Governments and other organizations could share information and avoid duplication of effort.

Mr Melia said the new national program will be funded on a project basis.

"Health and Welfare is not establishing a pool of money to give out to participants. Rather, the ministry is promoting collaboration among groups to reinforce the independent effort of all."

Advocacy role is necessary now: lung association

By Rhonda Birenbaum

OTTAWA — The Canadian Lung Association, concerned that the incidence of smoking is not declining fast enough, has decided to take a more aggressive role in lobbying government for action — even if it upsets the tax department.

"The smoking problem is not getting any better, despite the things we've been doing for the last 15 years," Peter Banks, association president, told **The Journal**.

"So, now we've adopted a more aggressive advocacy role. We had some concern about losing our charitable licence, but I feel so strongly about it that I am going to attack the issue. Even if the rules (about charitable licences) don't change, I would lobby anyway and hope for the best."

The federal revenue department has an unwritten rule, Mr Banks explained, that charitable agencies cannot actively lobby in a political manner. In the past, agencies that did so were threatened with the loss of charitable status. Volunteer and other organizations require charitable status and licences so that tax-deductible receipts for donations can be issued.

The lung association, however, is waiting for Revenue Minister Perrin Beatty to "change the rules" on lobbying.

"We submitted a brief to the Minister of Revenue telling him what we thought was wrong with the rules," said Mr Banks.

"We also tried to show him the importance of the smoking problem, and why we need to lobby for legislative changes."

Since they submitted their brief, Mr Banks said, the revenue department has called for submissions from other charitable groups.

"I think he seems to be enlightened now," he said, of Mr Beatty.

The focus of the lung association lobbying efforts is a push for legislation banning all tobacco advertising and promotion.

However, Health Minister Jake Epp is reluctant to support a legislative ban.

In an interview with **The Journal**, Mr Epp said: "Obviously, I'm going to look at that (the legislative ban on tobacco advertising) very carefully. The legislative proposal needs serious consideration. It has validity, but I think voluntary action is much more ideal."

Manitoba pharmacists suggest limits on prescriptions

By Maureen Brosnahan

WINNIPEG — Manitoba pharmacists want to limit the amount of prescription drugs a patient receives at any one time, to prevent drug wastage and potential abuse.

A resolution, passed at the annual meeting of the Manitoba Pharmaceutical Association, calls for the dispensing quantity of narcotic analgesics, anabolic steroids, anti-depressants, some antibiotics, benzodiazepines, and other controlled drugs to be limited to 34 days.

Quantities for all other drugs would be limited to 100 days.

Stewart Wilcox, registrar of the association, told **The Journal** pharmacists felt the resolution would ensure better medical practice. Many times, large quantities of drugs are wasted or go unused because a patient stops taking them, or their medication is changed.

As well, he said, large quantities of prescription drugs being given out at any one time could promote abuse, and pose a danger to children.

Mr Wilcox said tighter controls on narcotic analgesics and other such drugs are necessary. "These are the type of drugs used in suicide attempts, and sold (illegally) to others. There's no limit right now except common sense."

Mr Wilcox said any move to limit dispensing quantities would require a change in legislation, something he plans to discuss with Manitoba's Health Minister Larry Desjardins. "As the law stands right now, the pharmacist cannot change the quantity of the prescription without permission of the doctor," he said.

Mr Wilcox admitted the association could be accused of having a financial interest in such a change, since pharmacists could collect more dispensing fees if patients filled prescriptions more frequently. But, he said, their main interest is in good pharmaceutical practice.

Mr Wilcox said doctors would still have the final say in writing the prescriptions, and there would be exceptions, such as people travelling out of province for months at a time.

Docs fined for R_x conduct

VANCOUVER — Four British Columbia doctors have been found guilty of unprofessional conduct in the prescription of the tranquillizer Valium (diazepam).

The BC College of Physicians and Surgeons levied fines of $2,500 plus costs on each of the four: Drs W. W. Tam; L. M. Thurston; K. V. Phord-Toy; and Mark Fisher.

Dr Fisher has appealed the finding to the BC Supreme Court.

The writ of appeal cites a failure by the college to find that Dr Fisher had been entrapped by police, and alleges that some members of the council making the decision were also members of the college's inquiry committee, and that committee members were consulted in his absence.

Nairobi delegates ponder world health issues

Joan Hollobon, contributing editor of **The Journal**, *was among the delegates and journalists who flooded into this East African city for United Nations conferences marking the end of the UN Decade for Women in July* (**The Journal**, *July, June). She reports:*

NAIROBI, Kenya — When the non-governmental organizations (NGO) world meeting opened here in the Kenyatta Conference Centre, it was the color, the incredible variety, and the vitality, as well as the numbers, that overwhelmed the visitors' senses.

About 3,000 women had been expected at the official opening, but 10,000 — one official told me — showed up.

And, as thousands of every race, color, and dress joined in, there was an extraordinary sense of common cause, of warmth and friendship, and also of the potential power that lies in international action to a common end.

At the University of Nairobi, clusters of women overcame language problems to communicate at workshops on the UN decade's themes of development, equality, and peace.

In the September issue of The Journal, Ms Hollobon reports on health issues — including abuse of alcohol, prescribed and illicit drugs, and the increasing use of tobacco by women — discussed at the government conference to review and appraise the achievements of the decade, and at the NGO forum.

NEWS

RESEARCH UPDATE

Nitrite/AIDS connection

Inhalation of volatile nitrites — while not the cause of acquired immune deficiency syndrome (AIDS) in the homosexual population — might well be a contributory factor. That's the conclusion of a group of Texas physicians from the cancer prevention and clinical immunology, and biological therapy departments of the University of Texas and M.D. Anderson Hospital and Tumor Institute, Houston. They stated that the metabolites of these are known to be mutagens, teratogens, and carcinogens in a number of animal species. In addition, volatile nitrites have deleterious effects on human lymphocytes. The researchers note that the possible immunosuppressive effects of the drugs "may allow expression of a virus having oncogenic potential that was previously suppressed" — such as the retrovirus HTLV-111 that has been linked with AIDS. In addition, the study traces the growth of volatile nitrite use among the homosexual population. Almost every reported case of Kaposi's sarcoma during the past three years includes a history of prior nitrite use, and the age of the group of AIDs patients in whom Kaposi's is developing is consistent with a cohort initially exposed to the drugs seven to 10 years ago.
American Journal of Medicine, May 1985, v.78:811-815

Botulism among drug addicts

Botulism has been shown to be another possible complication of chronic drug abuse. This discovery was made following reports in 1982/83 of a series of six drug abusers from widely separated parts of the United States with a neurologic illness characterized by a symmetric descending paralysis. Five of the patients were parenteral drug abusers, while the sixth was a heavy, intranasal cocaine abuser. All of the patients had a clinical course of illness compatible with the disease. In two of the patients, the disease was confirmed by laboratory tests. Because none of the patients had histories suggestive of food-borne botulism, the rarer diagnosis of wound botulism was made. The eight US physicians who prepared the report stated doctors should consider this diagnosis "in any patient with a history of parenteral or heavy intranasal drug abuse who presents with cranial nerve dysfunction progressing to a descending symmetrical paralysis."
Annals of Internal Medicine, May 1985, v.102:616-618

No alcohol, but reactions to disulfiram cited

The possibility that organic solvents can cause the same reaction as alcohol in patients receiving disulfiram (Antabuse) therapy has been raised by a pair of Colorado researchers. Drs George Scott, MD, and Frank Little, PhD, of the Southeastern Colorado Family Guidance and Mental Health Clinic reported two cases, 31 years apart, of patients taking disulfiram for treatment of alcoholism. The patients reported disulfiram-like reactions such as flushing, tachycardia, and nausea, when painting in an enclosed space and working with a compound containing "mineral spirits" respectively. The researchers said that it is reasonable to think that "a number of commonly encountered solvents other than ethyl and other alcohols, when ingested or inhaled, may go through a similar process of metabolism in certain patients and, hence, may be capable of producing disulfiram reactions."
New England Journal of Medicine, March 21, 1985, v.312:790

Pat Rich

Data expected to have national impact

PRIDE surveys 180,000 US kids

By Elda Hauschildt

SASKATOON — A quick and inexpensive survey of youths and drug use is generating such massive data in the United States, the sponsoring agency expects it to have national impact.

"We've surveyed 78 different school systems in 21 different states, for a total of 180,000 kids, grades six through 12," Thomas J. Gleaton Jr, EdD, co-founder and director of PRIDE (Parents' Resource Institute for Drug Education, Inc) in Atlanta, told **The Journal** here.

"Even though they're not random samples, they are so massive that it gives you good data.

"We're looking at our data in the southeastern sector of the US, comparing it to Johnson's senior survey." Lloyd Johnson, PhD, is director of the annual US survey of drug use among high school seniors (**The Journal,** June).

"If we're on target with the senior survey data, and if we can be on target with the household survey for our area, then we'll have even more confidence we're getting good data. Right now, it looks like we're really on target."

The PRIDE survey, first set up in 1980 and honed down to its present form — 108 questions with a 15 minute response time — in 1982, costs only 28 cents per respondent to give. One data run costs $50.

"We can do it probably cheaper than anyone else can," Dr Gleaton said.

"The value of our survey is that it's quick, and you can determine pretty much what's happening in your community — in your child's school. That's what parents want. It can happen now, and we can do about a two-week turn-around for them."

Dr Gleaton, who was in Saskatoon for the first national conference of PRIDE CANADA, a Saskatoon-based parent group (**The Journal**, July), said it's the "here and now" aspect of the survey that has made it popular in the southeastern US.

"It's practical," he said. "If you want to know what's happening in your daughter's class, say, with kids in grades six through 12, you give the survey. Then, you go back and do curriculum based on what you've learned.

"We know in our area of the country, for example, that there's

Gleaton: 'we're really on target'

no reason to do a curriculum unit on marijuana in the 10th grade, because most of the decision will be made by the time they finish the 9th grade.

"So, we're saying don't wait to do your curriculum; do it in grades five and six, if you want it to be a preventive measure. Then, you follow it up with supplements along the way, keep them updated with what we're finding out in new research."

BCMA wants tobacco tax tripled

WHITEHORSE — British Columbia doctors want the provincial government to triple the tax on cigarettes during the next year.

This resolution, and several others aimed at discouraging smoking, were passed by physicians here at the annual meeting of the British Columbia Medical Association (BCMA).

The move to increase taxation was initiated by the BCMA's tobacco and illness committee, whose chairman used the 1984 report of the Canadian Tobacco Manufacturer's Council to show how important taxation is to the industry.

Fred Bass, MD, quoted the report as saying: "There can be no doubt that taxation policy is the dominant factor in the determination of the industry's future viability."

He said he was angry that the tobacco industry apparently placed the viability of its continued existence against the "viability" of cigarette smokers.

Resolutions to ban smoking on commercial airlines, halt government subsidies to the tobacco industry, eliminate the sale of tobacco in hospitals, and ban smoking in hospitals except in designated areas and by designated patients were also adopted.

The hospital-oriented resolutions started as an attempt to encourage a blanket ban of smoking in hospitals until Dr Bass and others pointed out this was unrealistic. "Precipitous evoking of smoking bans doesn't work," Dr Bass said after the meeting.

At the meeting, doctors also restated their position in favor of raising the drinking age to 21.

The recommendation was made by the emergency medical services committee. Committee chairman Norman Hamilton, MD, said: "There is no doubt it is an idea whose time has come." He said United States President Ronald Reagan has ordered all US states to take a similar step by next year.

The BC physicians also voiced opposition to any government attempts to legalize the sale of alcohol in grocery stores.

Recommendations made at the meeting must be passed by the BCMA board of directors.

That was the beer that — almost — was

By Wayne Howell

"Look at that — just look at that," said Professor Bottomsworthy as he ushered me into his office. He was holding a somewhat-yellowed, August 1981 issue of **The Journal** in one hand, and stabbing away at it with the other. He waved me to a chair and raved on:

"Thieves, scoundrels, rapscallions, rogues, duplicitous scum, mountebanks . . . ."

He continued in this manner. While he ranted, I took the opportunity to examine **The Journal** article that had incited his wrath. It was one of mine. It was my usual, straight-forward account of an interview with the professor. The subject was beer advertising. I couldn't see why it made him so agitated, and I told him so. That was a mistake. He responded by slamming a brown beer bottle down on the desk.

"More than one-million cases sold last year in the United States," he growled. I looked at the label on the bottle. And then I understood.

Although he is a tenured academic, the professor does dabble in commercial ventures from time to time. Much as he loves the prestige that goes with holding the McLuhan-Jung Chair in Contemporary Commercial Culture, he also loves the idea of becoming filthy rich. And so I knew why the success of Grizzly beer, with a label showing a mean-looking grizzly rampant on hind-legs and spoiling for a fight, had angered him.

In 1981, the professor had enlightened me as to beer-advertising concepts. He had explained to me that Moosehead beer from New Brunswick had fast-tracked itself onto the top 10 import list in the US because of its north-woods, macho image, exemplified by the profile of a huge, male moose that dominated the label. And, he had shyly shown me his own Canadian export beer "concept."

"It goes the evergreen concept one better — this is a *bona fide* Moosebuster if there ever was one," he had crowed in 1981. I had had to stop him and ask what the "evergreen concept" was, and he had explained to me that it was a Madison Avenue advertising approach rooted in the assumption that, despite Expo 67, the Royal Winnipeg Ballet, and Robertson Davies, people in the US still perceived of Canada as a primitive paradise of pure air, snow-capped mountains, spring-fed lakes, and wild animals.

It appeared at the time that the professor's concept did go the "evergreen concept" one better — at least in one sense. He had pushed the "primitive paradise" further north. He had sketches of a prototype beer label featuring the hairiest, meanest-looking, scruffiest Canadian animal of all — the musk ox. And, he had wonderful descriptions of a television advertising campaign for Musk Ox Ale, with scenes of musk oxen goring wolves on the snow-swept tundra, intercut with young men making eyes, over mugs of Musk Ox, at smiling blondes in chi-chi US bars.

He had packaged his "concept," and had sent it off to major breweries throughout North America. But, despite his relatively modest royalty demands for the Moose-buster idea, this fertile seed of his intellect fell upon stony ground. No brewery was interested.

And so he had to watch from the sidelines as Moosehead increased its US sales by 30% annually, riding the "evergreen express" to the point where it was the fourth most popular import. Moosehead owner Derek Oland began to boast that Moosehead was out to dethrone Heineken as the number one imported beer in the US. And then — oh the horror of it, the ignominy of it — three years later, he had to watch as Amstel brewery of Hamilton, Ontario introduced Grizzly into the US market, without so much as a tip of the hat, or a 50-cents-per-case royalty in his direction.

"I can see why you're angry," I said.

"The curse of the truly great thinker is that he is always ahead of his time," he said, shrugging his shoulders and scowling at the Grizzly label, which he obviously considered a pale imitation of Musk Ox Ale.

"All the same," he continued, "the Bear will probably give the Moose a run for his money in the 'evergreen' sweepstakes; it is no secret that the Bear was introduced to take on the Moose because the Moose is after Heineken for the number-one spot — and the Bear is, of course, really a stalking-horse for Heineken, because that's who really owns the Bear's parent brewery."

"You're losing me," I confessed. (The Canadian grizzly-bear a stalking-horse for the Dutch?) He ignored me.

"Think of it," he said, "two huge Canadian macho-mammals battling for the hearts and minds of beer-drinking US citizens — it's awesome, truly awesome.

"We've captured 30% of the import market with 'evergreen concept' beer, beer that's 'hearty and robust, with a head as pure and white as virgin snows building on the shoulders of Mont Tremblant, and the color of gold — Klondike gold.' Beer with a taste of the wilderness."

I thought he was quoting one of his own ads for the ill-fated Musk Ox Ale, but it turned out he was quoting from an US radio ad for Moosehead. I broke up at the idea of virgin snow on the shoulders of Mont Tremblant.

"Laugh if you like," said the professor, "but, it sells beer in the US. So, let's not spoil a good thing: if someone from the US ever asks you about that mysterious mountain with the pure white virgin snow, don't tell him it is only a short drive from Montreal and is criss-crossed with ski-lifts and ski-tracks. Let him keep his quaint, 'evergreen' illusions, and keep drinking our beer. It's good for the balance of payments, if nothing else."

FEATURE

AA — more than founders would have dared to hope

World's pioneer self-help group 50 years on

By Joan Hollobon

TORONTO — When a New York stock analyst and an Ohio physician got together in Akron in 1935, both hanging onto sobriety by a thread, they could not imagine that 50 years in the future their idea would be a worldwide organization with at least one million members in some 114 countries.

Indeed, they probably would not have dared such a hope four years later; in 1939, Alcoholics Anonymous (AA) still had only 100-or-so members.

Today, AA is widely praised as the world's pioneer self-help group, and one of the most effective battlers against alcohol.

Gordon Bell, OC, MD, founder of the Donwood Institute in Toronto, whose pioneering work with alcoholics 40 years ago put him under suspicion of medical malpractice, told a symposium recently that the establishment of AA was "the most significant phenomenon in the whole addiction field in this century."

He said that AA's "caring milieu" and its community, rather than medical, model "were things I felt we should hold on to."

But, AA is also criticized as simplistic and superficial, merely a crutch alcoholics exchange for the bottle, sometimes for a lifetime. It is even derided as a quasi-religious cult, fanatical in its insistence that lifetime total abstinence and loyal adherence to its 12 steps and traditions are the only way to salvation.

Derision defused

Also, since AA is "not scientific," lacking controlled studies, its success and failure rates can be no more than estimates. Even membership figures are estimates because of the decentralization that makes every group autonomous. International headquarters in New York is informational, not AA's Vatican. Canada, where AA started up in 1941, is estimated to have approximately 70,000 members.

But, the 50,000 AA members from more than 40 countries, who converged on Montreal for the Golden Anniversary International Convention in July, were indifferent to criticism or derision: for them, AA is a way of life — many insist it literally saved their lives — and the sneers and criticisms are irrelevant.

Their answer — "It works." The critics reply: "It only works for some — where are your failures?"

Curtis M., an official at AA World Services in New York, says, "AA has no scientific basis, but it's successful. . . . The scientific community has always been baffled by AA, yet it has been the scientific community, doctors and professors, who have helped AA survive right from the beginning. . . . It's an interesting, paradoxical situation."

He told **The Journal** he went to hundreds of meetings in his first year, "but, I believe it was the difference between life and death."

Many among those at the Montreal conference have attended AA meetings for years, like Tom H. of Toronto: "I was coming off a hangover, and I stopped in a telephone booth and called AA. I don't know why. I thought they'd send me some books or something, but they sent a guy around to see me instead. It took another two or three years though before I quit.

Montreal: all nations, religions, ages

"Finally, I went to my doctor one day. I was such a mess they wouldn't let me sit in the room with patients, and he got someone (from AA) to me. That was 1956."

What keeps people like Tom going to AA groups every week for 29 years? Why would 50,000 people travel thousands of miles to attend a meeting patterned closely on those they go to probably several times a week at home?

For many, it is gratification from helping others — a kind of service club with a single focus. Indeed, helping others or "passing it on" was from the beginning considered essential to each person's own success.

This missionary aspect and the strong emphasis on reliance on "a Power greater than ourselves" bother many critics.

Religious rituals

AA was founded on an unabashedly religious basis, in a broad, non-sectarian sense, and meetings today follow a structure similar to a non-sectarian religious service, with a "liturgy" — recitation of the 12 traditions, a brief prayer, reading of the same passage from the book describing "the steps we took," the admission of alcoholism, and of turning "our will and our life over to God as we understood Him."

The meeting (service?) ends with the group (congregation?) linking hands and reciting the Lord's prayer.

Considering that AA membership includes adherents of many religions and of none, inclusion of a prayer generally considered Christian seems odd, but in fact, despite its origin, the actual words of the prayer are not specific: they could apply equally to any "higher Power" or to "God as we understand him," in AA phraseology.

An AA pamphlet notes: "Many people call it (a higher power) God, others think it is the AA group, still others don't believe in it at all. There is room in AA for people of all shades of belief and non-belief."

Certainly, many congregations might envy the sense of closeness and fellowship. Even the unvarying structure may serve a valuable purpose, psychologically.

Harvey Brooker, PhD, a senior psychologist on the adult service at the Clarke Institute of Psychiatry here, told **The Journal** addictive personalities tend to be dependent, so "this kind of authoritarian approach is attractive because it answers questions."

He shrugged off the criticism that AA is a crutch.

"Sure, why not? It's a help. We are talking about people who are really disabled, who have had their lives disrupted."

Physicians and psychologists have not had much success treating alcoholism — "behavior therapy hasn't helped a whole lot," he said.

Critics see the "crutch" as a limiting factor, inhibiting flexibility and openness to new experiences, but "it's a trade-off with being able to live a productive life and not drink."

Sense of solidarity

AAs, said Dr Brooker, get a lot of mutual support, "a sense of solidarity from people who have similar disabilities . . .. You get a group of people who have become a functional community, with a shared set of values, a sense of belonging."

Controversy continues whether alcoholism is an illness. Is this view a cop-out, allowing alcoholics to shuffle off responsibility?

Dr Brooker said alcoholism may have been called an illness "to make it more acceptable, less a moral failing, and also something that presumably can be treated by health professionals . . . ."

The stories of the two founders of AA record the extent of the moral condemnation accorded the alcoholic 50 years ago.

In his talk to the Ontario Medical Association symposium, Dr Bell confirmed this: after the Second World War the stigma was sufficient to extend even to physicians trying to treat alcoholics. In 1949, he was quite pleased when his fledgling practice was visited by three senior physicians. Only 20 years later did he discover they constituted an official committee from the medical profession in Ontario sent to determine if he was engaged in some form of malpractice.

Dr Bell attributed much of this opprobrium to the emergence in 1830 of the temperance movement, whose teaching that alcohol was evil and drinking in any form a sin, resulted in a punitive response to those with alcohol problems.

Heather Graham

The temperance movement was so effective that public and professional reactions to problem drinking remained frozen for more than a century, Dr Bell said.

Several years ago, **The Journal** published an exchange of correspondence on AA as "the only way," vs "going it alone."

A Vancouver woman wrote that while AA had "done more good than any doctor or psychiatrist," and was a "vital first step," she believed it should be only a stepping stone, but going it alone was discouraged. She found AA members lived only for meetings, made friends only among other AAs, and were "afraid to face the world and its responsibilities."

Bill G. denied most AAs have only AA friends. But, one practical value of such an international fraternity, he said, is that an AA member can always find a group or an acquaintance, particularly if the going gets tough, almost anywhere in the world.

While maintaining its traditional independence, refusal to engage in controversy or to "endorse or oppose" any cause, AA today is placing greater emphasis on cooperation with others.

A pamphlet, revised in 1980, notes: "In many countries, the alcoholism picture is changing rapidly. Even in AA, the picture changes constantly." For example, some early AA members had to play "amateur doctor for alcoholics in the DTs," or provide "food, shelter, and loans to indigent drunks," while today there are many professional and social services available.

Outsiders assist

The same pamphlet notes that modesty wins more friends than "smugness, arrogance, or a know-it-all attitude. Saying 'We know the *only* way to recovery' is an egotistical luxury we can no more afford than we can afford resentments."

The longer AA members stay sober, the more likely they are to say that anything working for recovery for the alcoholic is good, whether hospitals, rehabilitation centres, government programs, religion, or psychiatry, "as well as AA."

A 1977 survey of AA groups in the United States and Canada found that one-third of AA members credited such outside assistance with directing them to AA.

Is mandatory attendance useful? Many alcoholics, including those who resented it at the time, report that often it is. Bill G. laughs now about having to attend his first AA meeting while in a residential program.

Bill G. added he had great difficulty admitting he was an alcoholic, and equal difficulty admitting his life was unmanageable, since, unlike many in the same program, he still had his wife, a job, and a home.

"There was a lot of self-analysis," and he found both AA and being away from his familiar surroundings in a 24-hour-a-day regimented treatment program helpful.

Both Dr Bell and H. David Archibald, founder and retired director of the Addiction Research Foundation of Ontario, believe that a combined clinical-AA approach often produces the best results initially.

The luckiest, said Dr Bell, are those who find AA can provide all the help they require, but some severely addicted to alcohol, or to drugs, need an initial period in an in-patient program.

Mr Archibald agreed AA can provide no estimate of those who find the program is not for them, "but it's a rare clinical operation, either, where you hear about the failures." Only programs with a carefully designed follow-up can record such statistics.

There is a selection factor in AA's statistics, however, in that success is calculated on "those who decide to come to AA in the first place." Mr Archibald told **The Journal** self-help groups frequently are more successful than professional clinical operations, as well as being very much cheaper, and AA is one of the best.

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

First ladies' forum 'devoid of serious intent'

Given the facts that illicit drug use almost always begins with and accompanies licit drug use, and that tobacco dependency leads the pack of all debilitating dependencies, United States first lady Nancy Reagan's historic first ladies' forum on drug abuse (June) has proven to be a bust.

Cigarette addiction in particular — despite its still-growing attraction for young females, went carefully (and strategically?) unmentioned.

Mrs Reagan's conspicuous avoidance of any mention of tobacco was no accident, given President Ronald Reagan's deep commitment to his constituents in tobacco-land. It would be playing with political fire to allow any discussion that might rile tobacco farmers.

Indeed, it is obvious that North Carolina Senator Jesse Helms, *de facto* chairman of the US tobacco lobby, and probably the most powerful president-maker in US history, calls the tune in the White House, and Mr Reagan dances to it.

When questioned some years ago as a presidential candidate about his position on tobacco, Mr Reagan's written reply to tobacco farmers still speaks for itself today. In part, he said:

"I want to assure you that I fully support this nation's tobacco price support program. Tobacco price supports have helped to sustain more than a quarter-of-a-million family farms in 16 states, and have proven to be an unqualified success. . . .

"My administration will end what has become an increasingly antagonistic relationship between the federal government and the tobacco industry. . . . Tobacco — no less than corn, wheat, or soya beans — should be viewed as a valuable cash crop with an important role to play in restoring America's balance of trade.

"I can guarantee that my own Cabinet members will be far too busy with substantive matters to waste their time proselytizing against the dangers of cigarette smoking."

Since Mr Reagan's letter was written, more than two million US residents have died from cigarette consumption.

Tobacco addiction — especially in the form of cigarette use — is wreaking more havoc on North Americans, individually and collectively, than all other drug-related problems combined. It seems only fitting that it should generate top priority concern in all contemporary forums alleging to seek out and promote appropriate remedial action.

To deny cigarette addiction a place of primacy on the agenda of the recent 'historic' meeting of first ladies was therefore, in my opinion, to dismiss those who smoke tobacco as expendable write-offs, and all of us as exploitable idiots.

Obviously, the smoking issue has become a political issue far too hot to handle by governments strongly addicted to tobacco revenue. And yet, the time has surely come for what I propose as the TEAM approach to the overall drug abuse problem (Tobacco, Ethyl Alcohol, Marijuana, etc). Indeed, as I see it, no up-to-date programs aimed seriously at dealing effectively with alcohol and other drug concerns can continue to afford to ignore the obvious nicotine connection.

Since tobacco then, is the undisputable king-pin of the drug abuse scene, it would seem obvious that shrinking this problem would concurrently, through the 'domino effect,' shrink the many tobacco-linked problems caused by alcohol and other drugs.

Reagan: empty words

It is with great regret that I must regard Nancy Reagan's opening plea to her fellow first ladies — "Mothers of the world, unite" — as empty words, utterly devoid of any serious intent to grasp the nettle and to grapple with the global drug problem from the top down.

George Lewis
Associate Professor
McMaster University
Hamilton, Ont

Reader questions stats in smoking costs story

I am writing regarding the article: Smokers paying their way, Ont health economists say (December, 1984).

I would like the source for this study. I see the study as non-valid, because many other possibilities were not considered.

Did it include costs to the government to maintain the families when the breadwinner died, or child care costs when the mother died; forest fire costs; circulatory diseases (deep vein thrombosis, leg amputation due to circulatory disorders); childhood respiratory problems?

Should *all* factors be considered, I believe you could double the quoted percent (70%).

Marlene Heintz
Wahnapitae, Ont

(Ed note: As the story said, the study involved only public funds spent on disease linked to smoking. Copies of reports No 112 and 128 can be obtained from: Program for Quantitative Studies in Economics and Population, Economics Dept, McMaster University, Hamilton, Ontario L8S 4M4.)

US pot source disputed

It is disturbing to see **The Journal** working as a conduit for government nonsense.

Where the United States Assistant Secretary of State Jon Thomas is quoted (June), "The marijuana smoked in the US comes, most probably, from Colombia or Mexico. . .," he is ignoring the fact that in some US states marijuana is today's largest money crop.

Nathaniel Polster
Editor
Adolescent Medicine
Washington, DC

Agape youth offers information

It's a pleasure to read **The Journal**, and I thank you for including my name on your mailing list.

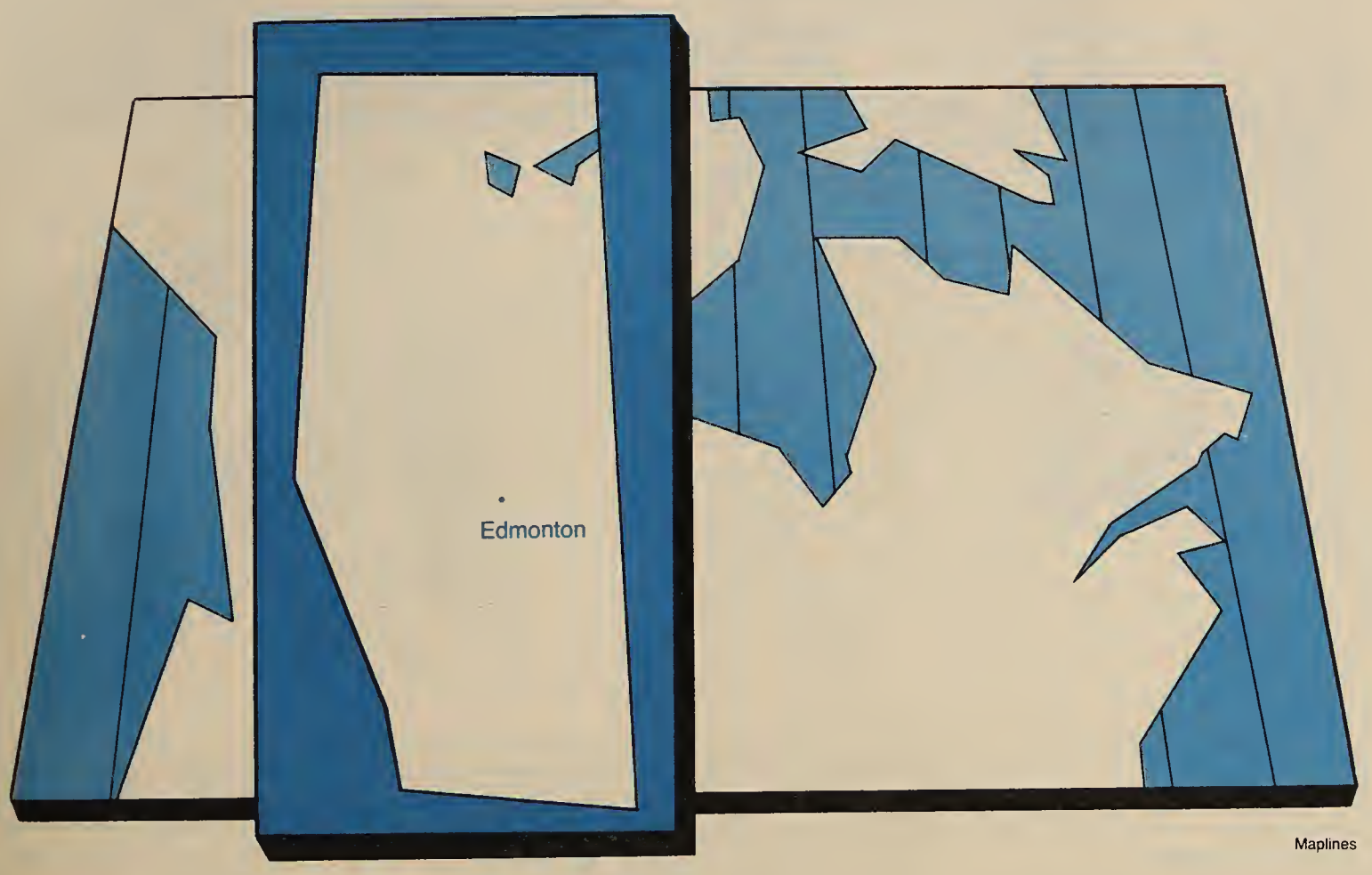
I am enclosing a short newsletter (our first) about Agape so that you have some background information about our group that is totally managed by youth for local youth.

Thank you once again, and I look forward to further correspondence between us.

Monica Kunz
Public Relations
Youth Agape Network
Toronto, Ont

Alberta Diary

The Journal



Maplines

A week in the life of the Alberta Alcohol and Drug Abuse Commission

Harvey McConnell reports from Alberta

EDMONTON — The Alberta Alcohol and Drug Abuse Commission (AADAC) appears to have everything going for it: adequate financing, prestige, political favor, public recognition, and acceptance. And, it hosted the International Council on Alcohol and Addictions' (ICAA) 34th Congress in Calgary this month.

The organization has come a long, long way since 1970 when it was moved from the Alberta department of public health to become a separate commission on alcohol and drug abuse. At present, AADAC has an annual budget of some $26 million, for a population of around two million, ranking it with the state of Alaska — both province and state are rich from oil revenues — as among the best-financed alcohol and drug programs in North America. It has 382 permanent employees, an impressive number of whom have been with the commission for a decade or more.

Throughout Alberta, AADAC has 19 area offices and six regions, providing prevention and treatment services. The commission directly administers four in-patient institutions, four non-residential clinics, and funds 33 agencies, with 33 different boards carrying out 14 different programs.

The chairman of the commission now is also a member of the legislative assembly. This provides excellent political visibility. With 12 other board members, the commission has virtually crown corporation status, although with some administrative differences.

The ICAA conference in Calgary, Brian Kearns, assistant executive director of program services, says, "served notice on the other actors in the communities, on both the national and international scene, that we are a valid actor, that we have something to contribute to the national — and we hope — international scene."

While AADAC does not intend to compete in areas now well-served, such as research and international training, "we think our prevention, and maybe our treatment, areas are certainly not behind the stream. We would like to think we might be ahead of it," Mr. Kearns adds. The priority is probably on prevention.

In the prevention field, the commission feels it has to be as slick in its promotions and media campaigns as the beverage industry. The campaign for teenagers, for example, shows upwardly-mobile young people, because research finds people like to reach up, not down.

One of the most sensitive and difficult areas, and one in which the commission moves gingerly, is assistance to more than 80,000 Natives, both treaty-Indians and Metis (mixed Indian, French Canadian, and Scots ancestry). This area is further complicated by questions of land rights, and oil and gas royalty payments.

Responsibility for Indians varied in the past, between the province and the federal government. The federal government now takes more responsibility through the Native Alcohol and Drug Abuse Commission. But, with the Metis, the problems were more overlooked as there was no special vested interest watching out for them. This has now been rectified.

Today, AADAC's leaders will agree that the commission is financially much better off than many provinces and United States states, that it has overall good *esprit de corps* among its employees, that it has gained wide public recognition and acceptance — with a concomitant increase in demand for services, and that the politicians smile on it.

At the same time, they are just as keenly aware that hubris precedes the fall of many high-riders, and they intend to see that this can't, and won't, happen to AADAC.

The Diary

MONDAY

Noon

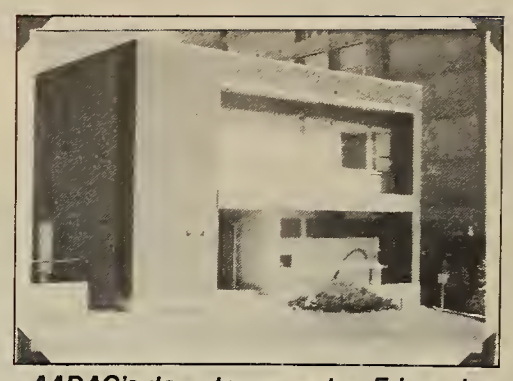
John Parker, director of the division of funded agencies, is a native of Alberta and cheerfully answers all the first-time visitor's questions about winter climate and people. On the drive into Edmonton, he presents a list of appointments: 24 in all, including trips outside Edmonton, over five days. Welcome to AADAC.

1:30 pm
AADAC Headquarters, Edmonton

Brian Kearns will be my link. Born and educated in Ireland, he came to Canada as a Roman Catholic priest, serving for a number of years in the Yukon Territory. There, he was forced to deal with alcohol and drug problems among his parishioners. He left the ministry to be executive director of the Saskatchewan Alcoholism Commission for five years, before moving to Alberta in 1984.

Alberta Diary

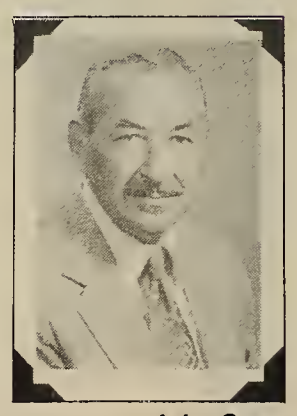
The Journal



AADAC's downtown centre, Edmonton

AADAC's west-end centre in Edmonton

AADAC



John Gogo

Jan Skirrow

Brian Kearns

MONDAY

1:30 pm

AADAC Headquarters, Edmonton

Mr Kearns fills in the necessary background about budget, population, size of AADAC, and some of its history. In his view, AADAC "focuses primarily on individual options and choices, and tries to influence people in making these choices."

This visit will show that it does.

2 pm

Meeting with Executive Director

Jan Skirrow has been with AADAC for 14 years, the last four as executive director. He has seen it grow out of "organized chaos" to an institution with a large budget, high visibility, and liked by the provincial politicians.

The commission has a great deal of well-appreciated flexibility, "and I think the reason we have that flexibility is that we have done a good job in exercising it," he adds.

"People like what AADAC does, and political people like it as much as anybody else. I think that has worked to our advantage. If you can make a good case, I usually find you can get what you want."

Commission Chairman John Gogo, a member of the legislative assembly as well, is very effective in ensuring that AADAC gets its place in the sun, and its share of attention in various political arenas.

"We are not a big operation," Mr Skirrow notes, "so we don't get a lion's share of anybody's time in the legislature — but, when we have something to say, we can usually get an audience there."

While Alberta's oil deposits have greased the financial wheels copiously since the 1970s, the mini-bust in the boom cycle has affected AADAC as it has every other organization. Mr Skirrow has no doubt the provincial government is in firm control over what happens in its name, and the bureaucracy is highly accountable.

The government decision on financial restraint three years or so ago has stuck, in his view, in a responsible way. In AADAC's case, "we had time to adapt to the change and we have been given the freedom we needed in order to be able to make the change.

"So, we haven't been told things must continue exactly as they were before, and we have got to do with less. They have said, 'Okay, we will loosen some of the rules that make it hard for you to operate in a different way, but you are going to have to do with less.' "

The net result has been a staff reduction two years ago of 3%, and by 2% last year. Whether 1985 will see a further reduction is uncertain. No one loses their job, but they can be shifted around. "We have taken the approach that it makes no sense to try and shave a little here and a little there. It is better to say we don't need that function any more, therefore we will eliminate that unit and place the staff somewhere else in the organization."

There is no question, if polls are to be believed, that AADAC has had a meteoric rise in public perception in the past four years, and Mr Skirrow attributes most of this to the media-based adolescent prevention program.

"In a poll four years ago, public recognition in the southern part of the province ran about 7%; it is now running at about 90%, and that makes a tremendous difference."

The commission now deals with 50% more people in treatment than four years ago, "and we have become known as *the* people in education and prevention of addictions in the province, and are in much greater demand by schools, by community groups, by everybody around, basically, for that kind of programming."

All of this is being achieved with slightly reduced staff levels, in many cases, than four years ago as AADAC becomes more efficient in the use of its resources.

Surveying the various AADAC programs, Mr Skirrow points out that "how you describe a program is very important." A good case is one called Drinking Decisions.

"In effect — and it is accepted as such — it is a way of people self-diagnosing, and it gives them the techniques and tools they can use to modify their own drinking practices if they want to. If they try it and succeed at it, great; and if they try it and don't succeed, then we strongly suggest they try another approach, be it the abstinence model, or whatever."

Alcohol remains the major problem in the province, but Mr Skirrow thinks the point may be reached soon where "we can at least hold our own."

Surveying the future, and trying not to be alarmist, "because so much harm has been done in the past by people being alarmist," Mr Skirrow suspects there will be more problems caused by people using a wide variety of pharmaceuticals, obtained both legitimately and illegitimately.

As for AADAC, "it is my belief that we shouldn't get much bigger, because I think we have a staff composition which is manageable. And, while the field may think that senior managers are isolated from the realities of the world they deal with, the fact is that, from my point of view, the organization is at a size where we can still understand what our field people are dealing with."

If one looks at a province the size of Alberta, and the number of people being treated each year, both through direct services and funded agency services, Mr Skirrow believes, "we have to be making a substantial dent in the number of alcoholics in this province. And, overall, I think anybody in this province who is motivated in some sense to seek some assistance for something that is wrong will get it, at this point."

3 pm

Policy and Planning Unit

David Hewitt, PhD, is a cheerful social psychologist who taught at Canadian and Dutch universities before joining the commission. His major focus is to draw together information to assist Messrs Skirrow and Gogo in understanding the background, and outlining alternatives, in which a problem can be approached.

From this, a decision is taken.

Dr Hewitt: "Part of the key to us in getting additional money for programs is that we do the background work necessary to justify the request."

4 pm

Division of Funded Agencies

John Parker is director of the division of funded agencies, funnelling AADAC money into 40 programs around the province. The programs are run separately; some are funded entirely by AADAC, while others are only partly. The list is long: detoxification centres, in-patient treatment programs, halfway houses, counselling services, and educational programs.

All of the programs dealing with Native people come under Mr Parker's aegis, and they are almost personalized: "The money comes from John Parker and John is OK."

Some $3.6 million a year goes into Native programs from AADAC's budget. The federal Native Alcohol and Drug Abuse Commission (NADAC) puts in roughly the same amount: more than $7 million, a not insignificant sum for helping an estimated 42,500 treaty-Indians and 40,000 Metis.

Mr Parker says, "Alcohol and drug use, particularly alcohol use, is endemic among the Native population. As much as 80% of them, really, are affected in one way or another."

Evelyn Kohlman, who works with Mr Parker, declares: "There is an increase now in violence, in suicides, in incest, and even more predominantly, in child abuse. There are almost no families who are not touched in one way or another."

A fatal mistake is to think of Natives as one homogeneous group: they are anything but, with significant linguistic, cultural, and tribal differences. And now, there is another difference in some cases: cash payouts for those living on lands where oil and

Alberta Diary

The Journal

Lawrence Major, Karen Webster, Bonnyville

Wendy Grosseth-Hutton (left), Lane Smith, Sharon Steinhauer, St Paul

Lydia Cardinal, Elizabeth Colony

gas reserves have been discovered.

In some cases, where programs have been in effect for some time and there are a good number of sober Indians, the cash payouts — often as high as $12,000 for every man, woman, and child — are put in the bank. In one area, though, a leading member of one band and his wife were hounded from their home after he suggested only one-third of the money the band received from oil and gas companies be paid out in a cash sum.

TUESDAY

8:25 am
Smokey Lake

The home-made cinnamon buns at the local cafe, as Ms Kohlman promised, were delicious. It was a short stop following a 6:55 am start from Edmonton. The district in St Paul lies 130 miles northeast, nearing the Saskatchewan border.

Ms Kohlman outlines the programs the funded agencies division handles, and explains with a smile that when Mr Parker hired her, "I told him I would work for him for two years only, and not a day longer." That was five years ago. She likes the job.

The normal job of supervising programs funded by AADAC is compounded in Native programs by Native politics. Diplomacy is the touchstone: "You cannot get involved in any way in Native politics. That is a sure way to see a program disintegrate before your eyes."

10 am
St Paul

Again, right on time, and over coffee, Lane Smith, director of the AADAC northeast region, outlines their current concerns and problems in administering an area which stretches from the Northwest Territories to a little way above Edmonton, and from Whitecourt in the west, to the Saskatchewan border in the east.

"There is no question our primary problem is alcohol," Mr Smith explains. "And, one of our major concerns over the past six months has been the mainlining of alcohol by students in Barrhead. Injecting alcohol into the bloodstream has been around for some time, but this particular group includes middle-class students travelling on the bus, who are high by the time they get to school.

"They get an immediate high, without the smell. They shoot rye whisky, or anything they get their hands on. The problem surfaced because the teachers started wondering why their students were dazed and out of it, yet they could not smell anything. They could not figure it out at first."

Sharon Steinhauer, a senior counsellor, adds that another problem is Lysol use, mainly among men who get drunk together in parks, or back alleys. She has sessions as well at the local corrections centre, "and you get guys coming off the streets who are using a lot of chemical stuff I have not even heard of."

Mr Smith points out his region is the second largest in the province, has five district offices, and because of the area it covers, offers opportunities for innovative programs quite different from those in the southern part of the province.

Whereas AADAC staff in the urban settings of Calgary or Edmonton can specialize, in his region AADAC employees have to double in many roles, from counselling to administration.

1 pm
Bonnyville

The Bonnyville Native treatment centre, about an hour's drive northeast of St Paul, is in a romantic setting; cedar-clad buildings with lawns rolling away to a large lake at the bottom of the hill. The guests, as they are called, have just finished lunch in the circular dining area. Everything in the building is modern, well-designed, impressive.

Karen Webster is director of the centre, which normally has 26 guests in residence, from any or all of the 11 surrounding Native reserves — Frog Lake, Cole Lake, Beaver Lake, Onion Lake, Saddle Lake.

Ms Webster says most of the guests have problems with alcohol, mixed in with pot smoking. "There is a lot of home-grown marijuana around here. We seldom have guests who are strictly drug addicts, as they are very hard to treat."

In general, the problems of Natives are no different than those of whites, although many people just assume the Natives are more susceptible.

Ms Webster: "It is their environment, their culture, their beliefs that are different from ours, and so are their coping skills. These are the things that make them possibly more vulnerable to alcoholism.

"Many of them have grown up in isolated areas, where they have just managed to scrape out an existence. They have alcoholic parents, and they have lived this way all of their lives."

Oil and gas right payments often add to the problems, rather than easing them. Ms Webster explains: "Some families are getting $500 a month for each family member, so they live well, have no need to work. But, what do they do with all their spare time? Having too little, or too much, there is little incentive, and there is nobody in the family system with a good job and a stable life to give support to others."

Lawrence Major was the first executive director of Bonnyville when it opened in 1976. He later went to Lloydminster as a counsellor for five years, before returning to Bonnyville as program coordinator.

Mr Major, who has been sober for 19 years, regularly arranges for AA members to come to the centre, so that the guests will find out "how it works out there, so they are not shocked or anything, when they go to an AA meeting. It is important that they know what to expect."

One of their former guests, a young woman, returns regularly to lecture on suicide among the Natives, and speaks of her own experience in trying to kill herself.

3 pm
Elizabeth Colony

A few miles outside Bonnyville, the paved road ends and the insect splatter on the windshield thickens as Ms Kohlman, under Ms Webster's instructions, turns left or right at each T-junction on the way to Elizabeth Colony, a Metis settlement with some 400 people in 82 households.

"We went to Bonnyville and asked if they would be willing to supervise a satellite program," Ms Kohlman explains. "Due to family breakdown and violence in the community, we wanted some kind of intervention program, and some kind of counselling."

Lydia Cardinal has been operating her one-woman counselling service from two small rooms for the past year. She is a native of Elizabeth, knows everyone, and knows every problem.

But, she explains, "even though I know what the problems are in families, I can't just go in and say 'you have got a problem.' That way I would have no clients. I wait, and gradually they come to me.

"One way of reaching the adults, espccially the fathers, is through the children. That is why I have organized a youth group, and they can take home pamphlets, which lie around the house, and are read. Communication is a big problem — in the family, in the home."

WEDNESDAY

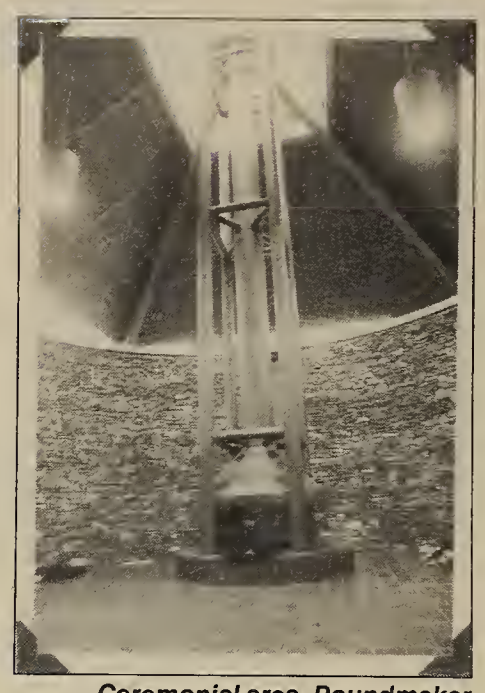
9 am
Provincial Programs, Media

Everyone agrees the media campaigns over thc past four years, aimed mainly at adolescents, have made AADAC a household namc in the provincc. And, while the current "Make the most of you" message might baffle some adults, it doesn't young people.

Ric Durrant, dirccor of provincial programs, points out teenagers "are interestcd in their own self-dcvelopment, their own direction and success, and it is simply a bandwagon we take advantage of. We havc put enormous energy into not being pcrceived as a typical addictions agency."

Alberta Diary

Leonard Blumenthal



Ceremonial area, Poundmaker

WEDNESDAY

9 am
Provincial Programs, Media

Before the campaign, few young people knew of AADAC, and what they did know, they didn't like. Today, they are so attuned that when AADAC's advertising agency in Calgary blind-test marketed various music tracks to selected teenagers, the response was often, "that sounds like an AADAC ad."

While two million dollars might seem a lot to spend on advertising campaigns, when television is involved, it does not last long. The ads take a middle road, with the hope that young people from all sections of the community will find a common theme.

Alcohol may be the real issue from the adult point of view, but as Mr Durrant explains, "we are really trying to talk about identity, peer influence, and social success. We figure if we can get important messages across, this in turn, will influence how kids make all sorts of important decisions, including how they use alcohol."

Everyone is loathe to make any claims at the moment — but they do know that "Make the most of you" is established with almost every young person in the province. This may, just may, be having some effect on alcohol use.

While the television campaign takes a middle road, the magazine *Zoot Capri*, produced for AADAC by a Calgary advertising firm, talks directly to youth groups in the province.

10 am
Program Resources and Theatre Projects

Thirteen one-hour television programs on alcohol and drug abuse will be aired in Alberta next winter, on educational Access TV in a coproduction deal. George Caxton, in charge of the programs, says, "We are using a group called Catalyst Theatre. We have used them over eight years or so for various programs, to demonstrate much of the information we are giving in the TV programs. We thought this is better than just straight interviews."

11 am
Impaired Driving Programs

Martin Parsons, director of the impaired driving program, has been gearing up for the latest program, announced by AADAC on July 4 for those with repeat impaired driving offences, and based on a program developed at Wayne State School of Medicine, Dayton, Ohio.

The courts or the traffic control board will require those designated as repeaters, who have had their licences suspended for from one to three years, to attend the weekend residential assessment and intervention program.

The focus of the program, which starts in the fall, will be on problems with drinking and the ways alcohol affects the major areas of life, rather than on the impaired driving issue.

Noon
Regional Services

Peter DeGroot, a transplanted Dutchman via New Zealand, is director of the Edmonton region of AADAC. The region runs in a strip from the Saskatchewan to British Columbia borders.

"On the regional level, we provide the impetus for coordination between both the funded agencies and institutions in the areas," Mr DeGroot says. "Although it is not written down, it is our responsibility to ensure there is coordination and cooperation. I think each of the regional directors knows this is an integral part of their function, and acts on it."

1:15 pm
Downtown Treatment Centre, Edmonton

Clients are getting younger — the average age is 33 and 34 — and most abuse alcohol and other drugs. "We find few we can call nice, clean alcoholics," and cocaine use is on the rise, according to Helen Reboud, director of the Downtown Treatment Centre, a walk-in clinic in the middle of town.

"We used to try to do appointments, but we found that many people wouldn't show. So, now we ask that they come in between 9 and 11:30 am and 1 and 3 pm, and promise somebody will see them," she continues. "It always varies, but every day new clients walk in. This Monday we had 15."

The clinic has 16 counsellors, a full-time nurse, a part-time doctor, and a psychiatrist. In May, they had 925 individual counselling sessions, and of those attending 248 were new admissions.

2:15 pm
Downtown Counselling Unit

Reverend John McNeil was putting in his last week as director of the day-counselling unit, before retiring offically at 65, although he knows he will spend much of his retirement time doing voluntary work.

The centre offers a full-day treatment program from 8:30 am to 4:30 pm for four weeks, or 20 days. It can give almost-immediate entry to clients who might have to wait to get into a residential facility.

Rev McNeil too, sees a rise in cocaine use. "People are still dabbling, as it is expensive, but we are seeing more and more cases. There is no question it will become like it is in the United States. It is only a matter of time."

3:15 pm
Community Education Services

This division is normally run by Toni Wispinski, but he was seconded for a number of months to coordinate the ICAA conference. Connie Moores has been acting director. The division provides a variety of services, from direct contact with the public through John Mitchell's youth program unit, to Colin Hatcher, who has encouraged establishment of employee assistance programs (EAPs) in the province. "We can say with a degree of pride, that AADAC has its own EAP program."

THURSDAY

9 am
Henwood

A morning visit to Henwood, which is wholly-funded by AADAC. It has been open since 1968. It has 64 regular-treatment beds, 12 beds for family members, and 20 beds for people from around the province who come in for regular training programs.

Bob Hunter, acting associate director, says that today 90 out of the 96 beds are occupied, but there is only a two-week waiting list for entry to the three-week program.

Wendy Stewart explains that the training courses are offered to anyone working in a situation where they may run into people with drug and alcohol problems. Those who attend the courses become involved with the clients, and this possibly changes some of their attitudes, helping them make referrals in the future.

3 pm
Poundmaker

A massive, circular, thunderstone sweat-lodge, which stretches to the ceiling and is entered by a small door, is the newest addition to Poundmaker, an AADAC-funded treatment centre for Natives located outside Edmonton.

Pat Shirt, who has been executive director of the centre for three years, explains that the spiritual ceremonies, including the pipe ceremony two nights a week, are very important parts of the program. The 90 clients sit on buffalo robes in a circle around the elder, who sits on his woven rug.

"They get a good feeling from this room, and many choose to sleep here at night, with their blankets on the robes."

During the first week in July, Natives from all over the province, and much of Western Canada, descend on Poundmaker for the annual powwow, with three days of dancing and celebration of sobriety.

In the past, "the white, middle-class social worker never understood the Native or his value system." While white clients were more voluble, counsellors never understood that the silent Indian "wanted to be sober, but he was just different."

At Poundmaker, "we teach them that Indians were more than just bows and arrows — they had culture, they had technology, they had a good system of government, and they had a good system of taking care of their families. There is a lot to be proud of, and they find that out."

Mr Shirt says the program is very AA-oriented, and adds, with a smile, "We realize it was discovered by two white men in Ohio, but we know the higher power is Native."

The Nechi Institute is part of the Poundmaker complex, and is a Native training centre which started in 1974 and is funded by both AADAC and NADAC. It teaches Natives the skills for counselling and management.

Friday

10 am
AADAC Headquarters

It is hard to believe, after four days of observing the gamut of AADAC services, that in its beginning in the early 1970s, "nobody wanted anything to do with us," as Leonard Blumenthal, assistant executive director of administration and services, and a 19-year veteran with the commission, says.

"Now, in many cases, we have more people wanting to be involved than we can handle. People want an AADAC presence in their community, and it is looked on as a positive thing."

Mr Blumenthal and Brian Kearns accept that AADAC today is rich, proud, and self-confident. "We will accept that — in moderate degrees," Mr Kearns concedes with a smile.

They both agree as well that they are always aware that, while the public and politicians seem to love them today, anytime, anything could happen. "It is like the heavyweight champion, there is always someone out there to knock you down," Mr. Kearns adds.

And, Mr Blumenthal is sure "the biggest problem we could run into is if we believe our own clippings."

Mr Kearns concedes there is good *esprit de corps* overall, "but I could point to a whole division where the *esprit de corps* is less than satisfactory, less than it was two years ago. But, only because we are tinkering around with it, I might add, and they don't like us tinkering around."

The commission must deal with reality: "Alcohol is obviously here to stay, and to take any other approach than that is crazy. There is a consensus: the guy out there knows that most people don't get into trouble with alcohol. We, on the other hand, see mostly those who do get into trouble.

"We should be presenting a balanced perspective to the public."

Mr Kearns believes the watchword is vigilance: "When you start dealing with people generically or stereotypically, there will be individuals for whom you perform a disservice. And, we could rigidify our programs to the point that they become out of touch with their clients, and managers throughout the system have got to guarantee we do not."

The Journal
33 Russell Street
Toronto, Canada
M5S 2S1

Warsaw: everyday social problems like food queues, overshadow public awareness of drug issues. Officials seesaw on true scope of black market in heroin trade within Poland

Official dogma mars Poland's war against heroin

By Thomas Land

GENEVA — Poland has introduced tough new restrictions on the cultivation of opium poppies.

The measure is part of a comprehensive law confronting the widening local heroin trade. Critics complain that the legislation, a compromise reached after years of national debate, has been trimmed too much in order to avert the wrath of the farmers.

Poland is plagued by the biggest black market for heroin behind the Iron Curtain, and exploited by a network of rapidly developing, indigenous criminal organizations. But, the country's ability to address the problem is hampered by the official pretence that drug abuse is a peculiarly Western phenomenon heralding the demise of capitalism.

Authorities discuss the issue in several voices simultaneously — sometimes under-estimating the true size of the black market for drugs in order to conform to dogma, and sometimes over-estimating it in an effort to draw public attention away from other, potentially more-explosive social problems.

The law enforcement authorities in Poland recorded 13,000 people abusing drugs in 1983, up from 8,000 in 1979. But the youth newspaper *Sztandar Mlodych* "conservatively" estimates the number of Polish heroin addicts at 150,000, and authoritative Western observers, quoted in *The Times* of London, and elsewhere, consider there may be up to 300,000 regular heroin users in the country, a large proportion of them child addicts.

Many Polish drug abusers depend on a highly addictive, impure form of home-made heroin. It is distributed by proliferating local crime organizations which form a lucrative link between opium poppy producers and consumers.

The poppy is purchased from peasants relatively cheaply and then crushed and boiled to create a morphine base. A simple chemical treatment turns it into a crude heroin ready for injection by syringes that are reusable, due to local shortage.

Poland is one of the world's biggest producers of morphine, with about 300,000 acres of poppy fields under cultivation for sale to the state-controlled pharmaceutical industry. By supplying criminal organizations, growers can earn substantial extra income.

The black market trade has been conducted relatively openly, because the police have done little to discourage it. Although the drug trade is recognized as the cause of recurring waves of petty crime, with a daily ration of heroin costing about 10 times the average daily wage, law enforcement authorities have been engaged in other areas of public order, such as the suppression of underground trade union organizations.

Penal sanctions related to drug control were provided under a variety of different legal instruments. "The sentencing policy has not substantially changed over the past several years," writes a Polish authority in the *Bulletin on Narcotics* published by the United Nations. "The sentence most frequently administered has been conditional suspension of the enforcement of punishment."

The new law is the first attempt in Poland to provide a comprehensive legal structure to cover the whole field of drug abuse, from production to consumption. It increases the legal power of the police to stamp out the drug trade and obliges various governmental organizations to mount prevention and treatment programs. Most importantly, it seeks to eliminate the black market by reducing the supply of the opium poppy.

Originally, the law makers intended to ban all private-enterprise opium poppy cultivation beyond the carefully monitored plans for the supply of the legitimate pharmaceutical industry.

In the end, they struck a compromise, prohibiting all private opium poppy production except in plots not exceeding 20 square metres, when special permission is granted by the local authorities.

Religious leaders from Scotland, Sweden, US meet

Churches can 'stimulate' efforts on addictions

STIRLING, Scotland — Issues surrounding alcohol and other drug problems must be tackled and solved in the workplace, say religious leaders from three nations.

The workplace is the proper setting because the effects of alcohol and other drug problems can be readily observed there, representatives from churches in Scotland, Sweden, and the United States said in a statement after an international meeting here.

The Church of Scotland's Board of Social Responsibility, the Swedish Ecumenical Christian Temperance Federation, and the US North Conway Institute, a Boston-based interfaith association for education on alcohol and other drug problems, met in Scotland to refine approaches to the "growing" international problem of addictions. The three groups believe that the religious community has particular qualifications for dealing with addiction problems of today.

Jonas Hartelius, secretary general of the Swedish Carnegie Institute, told the conference that drug abuse is "a contagious phenomenon that has reached epidemic proportions throughout the world." He said employers have no clear guidelines on what to do about employees' drug problems.

Negative effects of alcohol and other drugs in the workforce, Mr Hartelius said, include absenteeism, accidents, deteriorating physical health, hygiene problems, psychological disturbances, memory difficulties, problems of motivation, lack of stamina, discipline problems, and crime.

Bengt Taranger, director of the Swedish Ecumenical Christian Temperance Federation reported that his organization sponsors 100 day centres for prevention and social rehabilitation, staffing the centres with full-time personnel and 5,000 volunteers.

Reverend David A. Works, president of the North Conway Institute, urged a broader global view of addiction problems. "As we see it, the churches of the world are called to stimulate healing efforts at the community level and also in workplaces."

Lachlan Hardie, welfare officer of the Strathclyde (Scotland) Regional Council, told of development of a formal written policy on alcohol-related problems for 108,000 council employees. The council provides public services to nearly half of the five million people living in Scotland.

He said the policy encourages early identification of alcohol-related problems. To heighten awareness, the council has launched a publicity campaign and presented lectures to work groups and seminars for executives.

James P. Richards, community services director for the Edgehill-Newport (Rhode Island) treatment facility, and president of the Massachusetts chapter of the Association of Labor-Management Administrators and Consultants on Alcoholism, said: "Today's employee assistance programs (EAPs) are achieving effectiveness rates of from 60% to 90%, and more than half of the problems identified by EAPs (in the US) have been alcohol or drug-related."

He said 10 years ago in the US, there were about 200 EAPs, and now there are at least 6,000. "But EAPs dealing with alcohol and drug issues will only be successful if they address the spiritual aspect."

George Collins, executive director of the Boston Globe Foundation, called for media support of "the responsible use of alcohol, and intelligent programs seeking prevention and education of our youths about drugs and alcohol."

Rev Frank S. Gibson, director of the Church of Scotland's Board of Social Responsibility which has about 80 centres and 1,250 full-time workers in social work, including alcohol and other drug prevention and rehabilitation, urged the church "to be the therapeutic group *par excellence* with a total, unitary approach." He stressed the need for "people-centred services" and massive educational campaigns on alcohol and drug issues.

"Our knowledge lacks fundamental unity," said Rev Gibson. "We need a holistic approach, and there should be no boundaries to our thinking. We have to increase our risk-taking ability."

By Tom O'Connell

Works (left), Gibson (middle), Hartelius: no boundaries on our thinking

Abstainers jam Ansvar roll

AUCKLAND, NZ — Business is booming in New Zealand for an insurance company solely for teetotallers.

When the Ansvar company opened its New Zealand office two years ago, it set out to write 10,000 policies in 10 years. Already it has more than 6,000.

Ansvar is owned by church and temperance groups, and the only exception to abstinence allowed policy-holders is communion wine in church. Profits support research on alcohol problems and promote the cause of abstinence.

The company currently offers only motor vehicle and household insurance policies. It says non-drinkers have proven internationally to be better insurance risks — more careful home owners and safer drivers.

Ansvar began in Sweden more than 50 years ago (the name means 'responsibility' in Swedish), and it now operates in 10 other countries.

Insurance: abstinence rewards

NEWS

Bitters: cornerstore problem

Herbal bitters a 'cheap high' for teenagers

By Peter Unwin

TORONTO — A Toronto alderman has proposed legislation to remove stomach bitters from cornerstore shelves and have them placed under the jurisdiction of the Liquor Control Board of Ontario (LCBO).

Acting on reports that teenagers are using stomach bitters for a "cheap high," Alderman Ben Grys wants to see more governmental control over the substance, including placing it under the control of a provincial body such as the LCBO. This would make stomach bitters a controlled substance, subject to the same restrictions as the sale of alcohol.

Stomach bitters are marketed as an herbal aid for digestive or other stomach problems, and have an alcohol content of between 30% and 40%.

The proposal to control the sale of stomach bitters goes hand in hand with other legislation proposed by Mr Grys: an interim control bylaw which prohibits for one year the establishment of any more bars or licenced restaurants in his west-end Toronto ward.

"We have acknowledged stomach bitters as a problem for some time," said Steve Johns, Mr Grys' executive assistant. "As far as we're concerned, they present more of a problem (than the granting of more liquor licences)."

Stomach bitters must pass before the LCBO for "tasting." If the board decides the product is not palatable enough to be defined as a beverage, it is cleared for sale in grocery and cornerstores.

"Most confectionery owners say they try to keep a handle on the problem. But, the bottom line is they're in business to make a buck. You can't expect them to completely alienate their market," said Mr Johns.

The proposal to control the sale of stomach bitters was presented to Toronto city council in January. City council approved the motion, and has passed on requests to amend the legislation to the federal and provincial governments.

NEWS AND COMMENT

Parliament recesses without legislation from Eastman report

OTTAWA — Changes in legislation that could further protect major pharmaceutical firms from competition with companies selling generic versions of their products have been delayed again, until September at least.

Parliament adjourned June 28 without Consumer and Corporate Affairs Minister Michel Côté making the expected announcement of moves that will influence the pharmaceutical industry, and possibly the price of drugs to consumers.

But, there are definite signs that an end is in sight to the 16-year lobbying battle between large multinational drug companies and those producing generic drugs. The battle has been particularly fierce in the last three years, since the federal government first announced it was considering changes in the current arrangement.

One indication that change is imminent was the release this spring of the $1.1-million report by the Commission of Inquiry into the Pharmaceutical Industry. Commissioned by the Liberal government in April, 1984, the 444-page report was prepared by University of Toronto economist Harry Eastman (**The Journal**, June, 1984).

The Eastman report supports compulsory licensing of generic drugs, proposes royalties to patent holders of drugs be raised from 4% to 14%, and that patent protection against generic competition be granted for four years after a new product is approved.

These changes would adversely affect companies which, since 1969, have produced generic versions of brand-name drugs. Companies making brand-name drugs, represented by the Pharmaceutical Manufacturers' Association of Canada (PMAC), argue that under the current system, they are discouraged from doing research into new drugs in Canada.

Following release of the Eastman report, Mr. Côté expressed concern about the effect of a royalties increase on consumer drug prices, and also said he was not bound by the report's recommendations because it was commissioned by the previous government.

On the other hand, Mr Côté has been quoted as favoring a six-year period of exclusivity for new patented drugs, rather than the four years proposed in the Eastman report.

A spokesman for Mr Côté told **The Journal** that the minister's mind is still "not totally made up" on the issue.

"We were supposed to put draft legislation in front of the House by the end of June, and we decided not to, because the minister decided to have more discussion and consultation during the summer," Louise Dufresne said.

Legislation would be forthcoming in the fall, she added.

This delay has upset the PMAC. In a statement last month, the association said it was "very disappointed" changes were not introduced prior to the adjournment of parliament," as was the stated intention of the federal government.

"During this further delay, generic companies enjoy an unfair advantage because the government has already announced its intentions to change the legislation."

On the other side, the Canadian Drug Manufacturers' Association (CDMA), which represents Canadian companies producing generic drugs, held a press conference at the end of June to urge Mr Côté to delay making a decision.

The CDMA focused on the fact the federal revenue department is suing two of the multi-national drug companies for taxes allegedly due on under-reported incomes from 1973 to 1978. The association said no changes that affect the industry should be made until this probe is complete.

Lung association could switch focus to marijuana: Chalmers

MONCTON — While bans on smoking in public places are proof "social attitudes can be altered," and that the war on smoking is bearing fruit, the focus may soon have to shift to marijuana, the New Brunswick Lung Association has been told.

Everett Chalmers, MD, chairman of the New Brunswick Alcohol and Drug Dependency Commission, told delegates their fight against smoking is being rewarded. "Almost every day we read about another hospital, industry, or institution" barring or curtailing smoking, and "more importantly, there is a decline in smoking and in the use of tobacco generally," he said.

Dr Chalmers said smoking, like other addictions, "is a complex social and behavioral problem" requiring "multiple approaches and techniques" to persuade confirmed smokers to stop and non-smokers not to begin. He said teachers, parents, and health professionals have to set a positive example.

He warned that many young smokers also smoke marijuana, and this is sometimes combined with phencyclidine (PCP) and lysergic acid diethylamide (LSD), "with very serious consequences."

Dr Chalmers said governments should increase support to organizations in the addictions field, referring to increased government revenues from alcohol and tobacco sales and fines imposed on lawbreakers.

"In times of monetary restraint and a depressed economy with increasing poverty, addictions tend to increase . . . . This leads to increased crime and vandalism, more suicides, spouse and child abuse, and physical and mental illness," he said.

GILBERT

". . . advertising did not cause the increase in smoking among women in the 1920s."

Women, cigarettes, and advertising

By Richard Gilbert

Does cigarette advertising make people smoke, or smoke more? Does advertising merely shift the preferences of smokers from one brand of cigarette to another? Or, is cigarette advertising wholly without effect on whether and what people smoke?

Anti-smoking activists are convinced that advertising increases the amount smoked. Tobacco manufacturers reply that they advertise to maintain their share of the market, or to secure selection of their brands. Few people argue that advertisers are altogether wasting the $2 billion spent each year in North America on the promotion of cigarettes.

The questions are difficult to answer because there are no good data. Research, mostly of dubious value, is available to support almost any opinion on the relation between cigarette advertising and cigarette use. This column is a plea for better research, with a note as to how some has been done, on the subject of women and cigarette advertising.

Poor research

Regrettably, the poor research is used even in prestigious scientific journals by authors who should know better. For example, an article in *Nature* in December, 1983 presented a graph of tobacco consumption vs advertising in Norway, to support a proposed ban on the promotion of tobacco products. But, the graph shows that the decline in tobacco consumption began *before* the ban on advertising. Thus, the author was being absurd (or disingenuous) when he used the graph to argue that an advertising ban in Britain would cause a decline in cigarette consumption. It would have been better to argue that a decline in cigarette use would lead to cessation of advertising.

Some of the interest in the role of advertising has been generated by feminists, concerned that women are being exploited by the tobacco industry. In her book, *The Ladykillers: Why Smoking is a Feminist Issue*, Bobbie Johnson noted that in the late 1970s about half of the cigarette advertising budget in the United States was spent on lower-tar cigarettes, "which have a special appeal for women," and a goodly proportion of this advertising appeared in women's magazines.

Kind words

Ms Johnson had some kind words to say about cigarette advertisers. They have done, she said, "what many other advertisers — and nearly all health educators — have not yet managed to do: they take women seriously. The women in the most successful advertisements are depicted as independent people with their own lives and interests. Today's woman, say the ads, knows how to get her own cigarette."

But, the most popular woman's cigarette at the time was Virginia Slims, with the slogan, "You've come a long way, baby." Ms Johnson noted, "The Virginia Slims girl may have come a long way, but she is still someone's 'baby.' She's only playing at being the independent woman. . . . By appealing to women in two conflicting ways, the campaign captures both the strengths *and* the vulnerabilities of women, and sells them nearly nine billion cigarettes a year."

Sexist advertising

The big puzzle for feminists is not explaining the apparent success of sexist advertising, but rather accounting for how the massive increases in advertising directed at women may have had little effect on how much women smoked. It is difficult to argue that women were being sent to their graves by ads in the *Ladies Home Journal*, when the 90-fold increase in the amount of cigarette advertising in this journal between 1960 and 1980 occurred at a time when the per capita consumption of cigarettes by women in the US remained essentially constant.

The 90-fold increase, by the way, was documented in the *New England Journal of Medicine* in July last year, in a letter commenting on the *Ladies Home Journal*'s centennial issue. The issue featured women's health as the "story of the century," noting how previous issues had helped inform the public about the importance of every disease women have except lung cancer, "the only epidemic involving this audience."

It is possible to argue that were it not for cigarette advertising in the *Ladies Home Journal* and other women's magazines during the last two decades, smoking by women would have declined substantially, as has smoking by men. Such an argument could be persuasive if it were buttressed by other evidence that advertising directed at women causes them to smoke.

Mythology

Part of the mythology of advertising and smoking is the belief that the large increases in women's smoking in the 1920s and 1930s were caused by advertising. Ms Johnson noted how the American Tobacco Company used the slogan, "Reach for a Lucky instead of a sweet," in a series of massive advertising campaigns designed to sell cigarettes to women as an alleged means of losing weight, and that "within two years of the 1925 launch, women had helped make Lucky Strike America's best-selling brand."

The problem with her analysis is that the advertising campaigns did not start until 1927, by which time smoking by women had become well established. The historical record has been charted by Michael Schudson in his 1984 book *Advertising in American Culture*. "It is clear," argued Mr Schudson, "that advertising did not *cause* the increase in smoking among women in the 1920s. News stories recorded the increase, and so helped accelerate it."

What caused the increase, argued Mr Schudson, was the adoption of the cigarette by women as a sign of divorce from the past, as a personal and social marker for "the new woman." Mr Schudson recorded how this happened. Factors included the widespread availability of cigarettes during the war, particularly mild cigarettes, and the novelty of women's wartime experiences both abroad and at home, doing work previously reserved for men.

The most potent factor, claimed Mr Schudson, was the media coverage of trends in women's smoking and the opposition to them. For example, in early 1925, the *New York Times* gave front page coverage to the results of a poll by the student council of a women's college (Vassar) on student smoking habits and attitudes towards them. Of the women polled, 45% said they smoked, 43% said their parents approved of smoking, and 66% voted to repeal the prohibition on smoking at Vassar.

These things were all happening in the absence of advertising, which kept to the usual business rule of following sales trends, rather than causing them. Mr Schudson did not deny a later role for advertising in women's smoking. His point was that ". . . by the time the ads first appeared, the legitimacy, or a least familiarity, of women smoking was rather well established." He concluded: "That advertising played a role in the late 1920s and after in promoting smoking among women should not blind us to the fact that this change in consumption patterns, like many others, had roots deep in the kind of cultural change and political conflict that advertising responds to, but rarely creates."

Changing patterns

Like other mysteries concerning advertising, its role in the changing patterns of women's smoking deserves much more in the way of profound analysis than it has been given. It will probably never be possible to do experimental research into the effects of advertising on smoking. Our guesses about the influences of advertising will have to depend on careful determination of the likely sequences of events that appear to co-vary, and resolute elimination of alternative hypotheses. Mr Schudson's historical and sociological analysis is a useful antidote to some of the polemic that is preached about tobacco advertising.

DEPARTMENTS

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

From Now On

Number: 658.
Subject heading: Treatment/rehabilitation.
Details: 27 min, color.
Synopsis: Although it is not known why some people become addicted to drugs, it is important when addicted people hit bottom and recognize their problem, that they get professional help. Social workers and psychologists work with patients individually or in groups to help them take responsibility for their recovery. It is also important that the whole family be involved in treatment. Unless the patient and the family continue to attend support groups like Alcoholics Anonymous or Families Anonymous, relapses can occur easily. Any relapse should be viewed as a reason to respect the power of the disease of addiction.
General evaluation: Poor (2.2). This film was not well-produced and was judged a poor teaching aid because of its boring presentation, and because it stressed that professionals are the principal means by which one recovers. On other occasions, however, its verbal message stressed the responsibility of the patient.
Recommended use: With a resource person, this film could be used with health professionals.

Enjoying Sobriety

Number: 661.
Subject heading: Treatment/rehabilitation.
Details: 25 min, color.
Synopsis: A man, shown packing a suitcase, receives a letter from a friend he knew in Viet Nam. The friend explains that he has had drinking problems, but now he is sober, and life is wonderful. He also mentions that he goes regularly to meetings to help him stay sober. This glowing account of his friend's sobriety convinces the man to unpack his bag and stay in the alcoholism treatment centre he was about to leave.
General evaluation: Fair-poor (2.5). Although this film contained a good message, the A/V group felt it was unrealistically optimistic.
Recommended use: With a resource person, this film could be used with recovering problem drinkers.

Recovery Roulette

Number: 657.
Subject heading: Alcohol/alcoholism — overview/treatment/rehabilitation.
Details: 21 min, color.
Synopsis: This animated film shows space-people in their spaceship observing earthlings. They discover that earthlings drink alcohol, and that even though they feel good for a while, they easily become addicted. One man, a recovering alcoholic, has not had a drink in three years, and the space-people follow him to see if he will slip back into drinking. He is shown under stress in preparing for a presentation at work, but goes to an Alcoholics Anonymous (AA) meeting instead of a bar. Later, he receives medication from his doctor for a cold. After his presentation, he decides one drink to celebrate cannot hurt, and apparently triggered by his medication, he returns to heavy drinking.
General evaluation: Fair-poor (2.7). The A/V group felt that this film was too long, and might discourage anyone who is attempting to give up drinking.
Recommended use: Because of the scientific concerns, a resource person is essential if this film is used.

Your Move

Number: 660.
Subject heading: Employee Assistance Programs (EAPs).
Details: 30 min, color.
Synopsis: A supervisor is concerned about an employee's deteriorating work performance. She is often late, has missed days, and work is often not completed on time. Fellow employees are angry that she is not carrying her load. The supervisor asks a fellow supervisor what he can do. He is advised to do something immediately because "these things only get worse." The confrontation interview goes badly and the supervisor goes to the EAP consultant to get help. On trying again, things go much more smoothly.
General evaluation: Fair (3.3). Although this film accurately portrayed the way an EAP consultation is to be conducted, the film takes too long to get its message across.
Recommended use: With a resource person, this film could be used in EAP supervisors' training.

New Books

by RON HALL

Dual Addiction: Pharmacological Issues in the Treatment of Concomitant Alcoholism and Drug Abuse

. . . edited by Mary Jeanne Kreek

The subject of polydrug use and alcoholism is addressed through an attempt to integrate basic pharmacological issues within the clinical setting, demonstrating the relevance of laboratory findings to those engaged in the management of alcoholism. The basic mechanisms of alcohol-drug interactions are addressed, laying the foundation for understanding by the clinician of the mechanisms by which alcohol may interfere with, or facilitate interactions with, other psychotropic substances. Specific interactions between alcohol and benzodiazepines or cocaine are reviewed. Concomitant use of alcohol and narcotics is discussed, and clinical data presented demonstrate naloxone's ability to attenuate alcohol-impaired performance. The use of a sweat-patch test to document alcohol consumption is explained, and it is felt that through this technique, alcohol dysfunction can be determined with a high degree of accuracy. The problems associated with the management of excessive consumption of alcohol among youthful drug abusers is reviewed. A selective guide to reference sources on the topics discussed is provided.

(Haworth Press, 28 East 22 Street, New York, NY 10010. 1984. 120p. $22.95. ISBN 0-86656-318-0)

Other Books

Toward the Prevention of Alcohol Problems: Government, Business and Community Action —Gerstein, Dean R. (ed). National Academy Press, Washington, 1984. Prevention and the community; taxing and spending; engaging the business sector; alcohol and the mass media; alcohol, youth, drunk driving; community cooperation to reduce alcohol problems. 174p. National Academy Press, 2101 Constitution Avenue NW, Washington, DC 20418. $14.95. ISBN 0-309-03485-X.

Public Health Implications of Alcohol Production and Trade —Walsh, Brendan and Grant, Marcus. World Health Organization, Geneva, 1985. Alcoholic beverages and public health; production, consumption, and trade; the need for research and action. 55p. World Health Organization, Geneva, Switzerland. ISBN 92-4-170088-2.

Step Four: Toward Recovery Through Self Discovery — Latson, John R. St Cloud Hospital, St Cloud, 1985. Booklet designed to assist in taking a personal inventory. 34p. St Cloud Hospital A and C, 1406 North 6th Avenue, St Cloud, MN 56301.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates
a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
¼ Page (280 lines) $250
c) Classified Ads $9.28 per column inch minimum 1" sold in ¼" increases

Circulation 27,318 (Canada, 21,412 USA, 1,907, Foreign, 386, Bulk, 3,613) Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents $16 per year
US & Foreign Residents $24 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount
Ontario residents billed as other Canadians

The Journal, 33 Russell St Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

34th International Congress on Alcoholism and Drug Dependence — Aug 4-10, Calgary, Alberta. Information: Jan Skirrow, chairman, 34th ICAA Congress, AADAC, 6th floor, Pacific Plaza Bldg, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

Canadian Addictions Foundation Annual General Meeting — Aug 5, Calgary, Alberta. Information: Leona Gallinger, Canadian Addictions Foundation, Pacific Plaza, Box 702, 10909 Jasper Ave, Edmonton, AB T5J 3M9.

23rd Annual Summer Conference of the International Transactional Analysis Association (ITAA) — Aug 8-11, Toronto, Ontario. Information: Dale Perrin, 2055 Dundas St E, Ste 104, Mississauga, ON L4X 1M2.

10th International Congress of Hypnosis and Psychosomatic Medicine, Introductory and Specialized Workshops and Scientific Program — Aug 10-16, Toronto, Ontario. Information: 10th International Congress Secretariat, 200 St Clair Ave W, Ste 402, Toronto, ON M4V 1R1.

2nd International Conference on Illness Behavior — Aug 14-16, Toronto, Ontario. Information: IBC, c/o Gut Behaviour Unit, Toronto Western Hospital, 399 Bathurst St, Toronto, ON M5T 2S8.

Royal College of Physicians and Surgeons of Canada — 54th annual meeting — Sept 9-12, Vancouver, British Columbia. Information: Robert A. Davis, coordinator, Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

Fundamental Concepts Course — Sept 16-20, Jan 13-17, 1986, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

United States

36th annual conference of the Alcohol and Drug Problems Association of North America — Confronting the Issues — Challenges for the 80s — Aug-18-21, Washington, DC. Information: Eric Scharf, ADPA, 444 N Capitol St, Ste 181, Washington, DC 20001.

North American Congress on Employee Assistance Programs — Aug 26-30, St Louis, Missouri. Information: Diane Vella, congress coordinator, NAC/EAP, 2145 Crooks Rd, Ste 103, Troy, Michigan, 48084.

9th World Conference of Therapeutic Communities — Sept 1-6, San Francisco, California. Information: Walden House Inc, 815 Buena Vista W, San Francisco, CA 94177.

Adolescent and Family Treatment: An Investment for the Future — Sept 18-20, San Diego, California. Information: Nomi Feldman, conference coordinator, 370 Tansy, San Diego, CA 92121.

1st National Association of Lesbian and Gay Alcoholism Professionals Conference — Sept 26-29, Chicago, Illinois. Information: NALGAP, 1208 East State Blvd, Fort Wayne, Indiana 46805.

International Youth Services Conference — Oct 6-9, Chicago, Illinois. Information: Bill Treanor, executive director, American Youth Work Center, 1346 Connecticut Avenue NW, Ste 925, Washington, DC 20036.

National Federation of Parents for Drug-Free Youth, 4th annual conference — Nov 6-9, Washington, DC. Information: Mary Jo Green, NFP, 1820 Franwall Ave, Ste 16, Silver Spring, Maryland 20902.

Association of Labor Management Administrators and Consultants on Alcoholism, 14th Annual Conference — Nov 10-14, Boston, Massachusetts. Information: Judith Evans, associate director, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

Association for Medical Education and Research in Substance Abuse, 9th Annual Conference — Nov 14-15, Washington, DC. Information: Dr G. Lewis, AMERSA president, Center for Alcohol Studies, Brown University, Box G, Providence, Rhode Island 02912.

10th Annual Southeastern Conference of Alcohol and Drug Abuse (SECAD 10) — Dec 4-8, Atlanta, Georgia. Information: Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, GA 30342.

Abroad

3rd International Conference on Alcohol and Drug Abuse — Aug 11-14, Lima, Peru. Information: L. Vasquez, MD, International Education, Peruvian College of Physicians, Wadsworth, IL 60083.

2nd National Drug Institute — Alcohol and Drug Use in a Changing Society — Aug 14-16, Darwin, Northern Territory, Australia. Information: Chairman, NDI Planning Committee, Drug and Alcohol Bureau, Northern Territory department of health, GPO Box 1701, Darwin NT 5794 Australia.

4th European Acupuncture and Alternative Medicine Symposium and World Symposium on Moratherapy and Lasertherapy —Aug 30-Sept 1, Copenhagen, Denmark. Information: Secretary General, scientific committee, Institute of Acupuncture, Colombo South General Hospital, Kalubowila, Sri Lanka.

12th World Conference on Health Education — Sept 1-6, Dublin, Ireland. Information: Mary D'Ardis, conference coordinator, 12th World Conference on Health Education, 34 Upper Mount St, Dublin 2, Ireland.

European Congress on Prevention of Alcoholism and Other Drug Dependencies — Sept 30-Oct 4, Opatija, Yugoslavia. Information: International Commission for the Prevention of Alcoholism and Drug Dependencies, 6330 Laurel St, NW, Washington, DC 20012.

International Congress on Local Authorities and Drug Policy — Oct 23-24, The Hague, The Netherlands. Information: Municipality of The Hague, Dr N. G. Geerts, MWV, PO Box 80.000, 2508 GA The Hague, The Netherlands.

ISSN 0228-863X
ISBN 0-88868-102-X

The Bermuda Royal Commission

A complex society faces serious social, drug ills

By Joan Hollobon

Bermuda, 20 miles long, two miles wide and 600 miles out in the Atlantic, could soon provide useful lessons to larger countries in handling severe alcohol and drug problems.

The Bermuda government wasted no time implementing major recommendations of a wide-ranging — and extremely outspoken — report by H. David Archibald's one-man Royal Commission into the Use and Misuse of Illicit Drugs and Alcohol, (**The Journal**, July, 1983).

The two-year study resulted in five special reports summarized in a final report submitted in March. The five special reports covered: education and training; the health and social consequences of alcohol, cannabis, cocaine, and heroin, plus a summary statement on AIDS; treatment and rehabilitation; the justice system addressing international issues and intervention, plus the justice system in Bermuda; and, alcohol — its impact on Bermuda.

The final report was accepted by both houses of Parliament in early June, and before month-end was before the Cabinet which immediately set wheels in motion for implementation of the major recommendation — the establishment of an independent National Alcohol and Drug Agency. Consideration of other recommendations began, and, indeed, some were already underway in the treatment field.

Bermuda Premier John Swan, in a June speech to the Bermuda Council on Alcohol and Drug Abuse, publicly affirmed the government's commitment to the program outlined by the Royal Commission.

He said appointment of the Royal Commission marked the first time a country "on a national basis" had done a study of its social problems.

Crediting Mr Archibald's report with changing his own attitude toward alcohol and other drug abuse by leading him to recognize them as social problems that cannot be considered in isolation, Mr Swan said: ". . . If you have not read that summary document *The Bermuda Mosaic*, I commend you to read it, because there lies, I think, the thesis for the analysis of the society. When it comes to the drug problem, it raises the questions: are we still institutionalizing segregation; do we still have recrimination; do people still feel insecure about their future? . . . People are really left out of the system itself and that's why I commend you read the Mosaic."

The Premier's comments underlined the open-mindedness with which Bermuda accepted the extensive study.

Calvin Ming Jr, administrator of the Commission, told **The Journal** from Bermuda, that the community at large "does not wish to lose the momentum built up . . . they want things done — like yesterday."

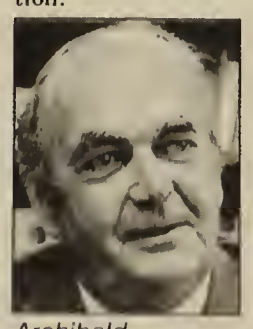
Mr Ming said because Bermuda is such a small place, it is common to walk down the street and have people come up saying, "Hey, let's do something (about it)."

He said that before the end of June, committees were already in place to look into such things as identification cards to cut down under-age drinking, and an employee assistance program. Ongoing weekly meetings with the business community and other groups had been instituted.

Also, the government already was looking into coverage of treatment by hospitalization insurance, and increased staffing for addiction services.

"The country has nothing but praise for Mr Archibald," Mr Ming said. The respect and affection are clearly mutual.

In the introduction to the report, Mr Archibald, founder and former director of the Addiction Research Foundation of Ontario, says, "Bermuda's people are capable, friendly, kind and loving, and they have a profound faith that no matter how serious the problem facing them, they — Bermudians — will somehow find a solution."



Archibald

Nevertheless, he is forthright in describing the serious social problems and frustrations of a complex society which, he says, form the "matrix" from which alcohol and drug abuse arise.

He lists such changes in Bermudian society as a rising divorce rate; more single parent families; more children born out of wedlock; breakdown of the extended family system, with inevitable impact on the elderly, and more child abuse.

Most potentially-serious for the future of the social fabric is the increasing alienation of youth, creating "a seedbed for civil unrest that results in severe negative consequences for Bermuda."

Overall poverty, however, is not a problem. Disparities exist, but the "astonishing development" of Bermuda during the past 20 or 30 years has produced a per capita income equal to that of many industrialized countries. Premier Swan noted in his speech that this can actually create problems.

Good wages give people "a sense of independence, but often without the corresponding acumen to deal with some of the problems they're confronted with."

In his addendum *The Bermuda Mosaic*, Mr Archibald describes a "substantial amount of stress and anger" among some young Bermudians, reflected in statistics showing more "crimes against a person, child abuse, and other social indices."

The route that ends with young, primarily black males, "almost completely alienated from Bermudian society," often begins with a punitive approach to primary school children (frequently from single parent families), who show early emotional or behavioral problems. Dropping out of school is followed by "hanging out" in groups, drug use, criminal conviction, and, often, prison.

The cycle may be prevented by the early intervention of alert, concerned teachers, or even later, by the "constructive use of leisure-time facilities, together with the influence of positive, caring leadership . . . . but, all too often, young drop-outs' only forms of recreational release consist of drugs and motorbike riding (frequently in packs at high speeds)."

A criminal record denies a Bermudian entry to the United States or Canada — "for him, the islands of Bermuda become a prison."

Maplines

This is important in the development of "the angry, young, energetic, black male." Mr Archibald told **The Journal**: "When you are caught on an island 20 miles long you get 'island fever' — everyone gets off the island once or twice a year."

Mr Archibald said alcohol is the major addiction problem. With approximately 90% of the young people consuming alcohol, "you are virtually reaching saturation point, and when you reach that point, inevitably, the health consequences and the fallout are tremendous."

In his addendum, Mr Archibald notes that his five special reports demonstrate that alcohol and/or drug problems know no racial or economic boundaries, so that "racial equity" is an important factor if Bermuda is to develop an effective program.

Although Bermuda freed its slaves in 1834, 30 years before slavery was abolished in the US, the islands remained segregated until 25 years ago. In 1960, blacks — then 62.5% of the population — were barred from tourist hotels and other public facilities. Sports were segregated, and blacks were relegated to the back in theatres and churches.

Today, while overt racism, one person to another, is condemned, "the country has not yet dealt with the area of institutional racism (which) occurs throughout Bermudian society — in government, business, banks, churches, schools, unions, political parties, clubs, and courts — and generally seems to be committed in the name of preserving business traditions and maintaining standards, a fact that makes it no less destructive of life and self-esteem."

The current population mix of, roughly, 60% black and 40% white provides "more of a racial balance than almost any other industrialized western country."

However, social problems are greater among the black community: for example, while 80% of white children live with both parents, only 51% of black children live in traditional, two-parent families.

Inequality exists in other areas: for example, "there seems to be a double standard between what is acceptable behavior for high-spirited young whites and what is acceptable behavior among high-spirited young blacks."

Mr Archibald found a fear of speaking out publicly on social issues, which he believes could seriously inhibit the development of the leadership required for the resolution of social problems.

The Commission heard of people who spoke out on unpopular issues being refused jobs or mortgages.

"It seems to me," he told **The Journal**, "that Bermuda has to learn to discuss publicly the major social issues the country has. In Bermuda, when you have a public discussion going, it quickly moves to a personal attack, rather than really trying to examine the issues — not agree, that's not the point — but to understand what the issue is and the various options. . . . I feel very strongly this is the kind of thing they have to learn to do. And, there has to be a good leadership to do that."

But, the real concern on the part of a broad cross-section of the community, including youth, provides grounds for optimism.

For example, most of the students surveyed thought marijuana use wrong and detrimental to health, and 66% were against liberalization of laws governing its use.

It is against this social background that Mr Archibald made wide-ranging recommendations designed particularly for early interventions to aid youth, with changes in the justice and police systems to ameliorate the impact on those committing relatively minor offences, but to greatly increase the penalties meted out to major drug importers and traffickers.

Consultants to the Royal Commission from outside Bermuda include: Michael Herbert Beaubrun, MB, vice dean, faculty of medicine, Eastern Caribbean Medical Scheme; Marvin M. Burke, RSW, executive director, Nova Scotia Commission on Drug Dependency; Michael West, PhD, professor of psychology, University of Sheffield, United Kingdom; and from the Addiction Research Foundation of Ontario, Toronto: Harold Kalant, PhD, director, bio-behavioral research; Donald E. Meeks, PhD, director of the School for Addiction Studies; Henry J. Schankula, MA, director of educational resources; Eric W. Single, PhD, scientist, social policy research; and, Reginald G. Smart, PhD, director, program development research.

THE BACK PAGE

Pure research requires society's support

Elda Hauschildt reports

CALGARY — Society must be willing both to finance and understand the need for "ivory tower" academic research in order to benefit fully from its applications, a leading Canadian scientist says.

Such research "raises hopes of greater selectivity in approaches to the prevention and treatment of addiction and its consequences," Harold Kalant, MD, PhD, told the 34th International Congress on Alcoholism and Drug Dependence meeting here. He is director of biobehavioral research at the Addiction Research Foundation of Ontario.

"But, today's practical benefits arise from yesterday's theoretical or basic research, and societies that wish to reap the rewards must be prepared to support, with patient understanding and adequate resources, the seemingly unpractical studies conducted in the 'ivory tower' of academic research."

Dr Kalant, also a professor of pharmacology at the University of Toronto, said biomedical research offers certain immediate, practical benefits to society, as well as "prospects for medium- and long-term advances."

Recent findings, for example, demonstrate the close connection between learning processes and tolerance to alcohol and other drugs, and "have important implications for treatment," he said.

"Tolerance, and the related phenomenon of physical dependence, probably play an impor-

(See Research — p2)

Vol. 15 No. 9 2nd Class Mail Reg No. 2776 TORONTO September 1, 1985

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Addictions experts want tobacco eradicated

Anne MacLennan reports

CALGARY — Smoking remains epidemic because of public apathy, conflicting interests within governments, and persistent efforts by multinationals to perpetuate tobacco use, an international workshop of addictions experts has agreed.

They reaffirm the view "tobacco control is a political issue requiring advocacy by those concerned."

They also stress addictions agencies "can no longer ignore" tobacco as an issue, and the goal should be "world-wide eradication of tobacco use."

R.A. (Ron) Draper, chairman of the workshop, told **The Journal** recognition of the fact control is a political issue was "the most important achievement" of the 5th World Conference on Smoking and Health, held in Winnipeg in 1983. Mr Draper is director-general, health promotion directorate, Canadian department of health and welfare.

The Calgary workshop was sponsored by the Switzerland-based International Council on Alcohol and Addictions (ICAA), the chief non governmental organization in the addictions field. Co-sponsors were the health promotion directorate, the World Health Organization (WHO), and the Alberta Alcohol and Drug Abuse Commission, host for the ICAA's 34th (centenary) Congress on Alcoholism and Drug Dependence, where the four-day workshop convened.

ICAA president H. David Archibald told **The Journal**: "We wanted a significant development at this Congress on smoking, to fulfill ICAA's commitment to becoming active in this area.

"The best way to promote real activity is to have a good, solid professional group address the issue. Tobacco addiction is directly generic to ICAA territory."

The workshop team will present its formal report to the ICAA board of directors later this year, for further study by a special committee of the board.

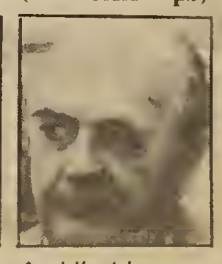
However, in a preliminary report to the Congress, Mr Draper explained how the team "positioned itself," listed four specific focal points of concern, and set out its recommendations to ICAA.

He said the team recognized "two decades of active thought, discourse, and strategizing for tobacco control," and the contributions of such organizations as the WHO and the international unions on cancer and tuberculosis, and wanted to build on past strengths.

(See ICAA — p2)

Congress logo

Draper



Archibald

Education, enforcement must work in tandem; UN drug chief

Prevention essential to global drug control

By Anne MacLennan

CALGARY — International efforts to control illicit drug production and trafficking will not succeed without parallel local and national efforts to prevent drug abuse.

This is the view of Tamar Oppenheimer, director of the United Nations Division of Narcotic Drugs, Vienna, and one of the highest-ranking bureaucrats in the international drug field.

She told **The Journal** that international control measures "can and must" continue. Particular emphasis now is on a multi-national approach to removing the fabulous profits from drug trafficking.

However, control efforts have moved from the astoundingly simple, in retrospect, to the astoundingly complex. Early in this century, the need was to limit opium poppy and cannabis production in a handful of countries to provide for medical and scientific needs only.

Now, with the explosion in numbers of producing areas, amount of production, and range of products, as well as the "daunting prospect" of synthetic drugs, confinement is an "ever more elusive goal," said Mrs Oppenheimer.

"What was appropriate in 1910 and in 1960 isn't appropriate in 1985."

Efforts to reduce supply must be counterbalanced by increased research, and education and prevention at the community level, to try to reduce demand for drugs in societies around the world.

Mrs Oppenheimer allows that while it is unrealistic to expect demand for drugs will disappear, "unless and until it can be restricted and contained, we face a continuing deterioration."

To contain the problem, she said, facts are needed. "What drugs are being abused, where are they being abused, and how, and, above all, why?"

It's in this area that more research at local and national levels is needed.

"I think we need to galvanize the academic and research communities to take both a deeper and broader view of the incidence of the problem and of the human and financial cost to communities and nations.

"For policy makers to know, or at least to have a perception of, the proportion of their resources they need to devote to this, they have to have some idea of what they are already spending across the society — not only in health care, not only for police and customs, but also in the courts, the penal institutions, in the time lost to the workplace, the terrible costs — because they're so depressing — of rehabilitation."

For now, she said, too many studies are at the micro-level; there's very little on the macro-level.

To provide the kind of information policy makers need — and that allows a proactive rather than reactive approach — research must at least strive to be consistent, and applicable, across local, national, and international boundaries.

"There's no need for every country, in this day and age, to reinvent the wheel."

She elucidated in an address to the 34th International Congress on Alcoholism and Drug Dependence, sponsored here by the International Council on Alcohol and Addictions (ICAA).

"We will only discover the facts we need if we consult together, and agree on how they may be collected and, thereafter, how they can be made available to interested parts of the formal and informal structures of the many governments and non governmental organizations which are now searching for a solution to the problems."

Mrs Oppenheimer also touched on the role of non governmental organizations (NGOs) — "part of the network of concerned organizations underpinning the more formal structures of government agencies and authorities."

She said ICAA has taken a "leading role in showing how an NGO can complement the work of national, international, and intergovernmental organizations.

"We regard non governmental organizations' involvement as essential in mobilizing the persuasive and supportive sectors of society in all our member states; their activities are a vital supplement to the work of those of us in the formal institutions primarily concerned with control."

Oppenheimer: elusive goal

Women in Nairobi . . .

. . . Pages N1 - N4

INSIDE

NEWS

Briefly...

That's entertainment?

WASHINGTON — Movie buffs in the United States may soon be advised whether films contain scenes depicting alcohol and other drugs in a glamorous or humorous light. The Entertainment Industries Council (EIC) is gathering support from parent groups and other organizations in its drive to establish a SA (substance abuse) sub-rating for movies. The EIC's objective is to encourage the entertainment industry to use their influence to ensure substance abuse is not shown without negative consequences, says executive officer Brian Dyak in the *Alcoholism Report*. The newsletter adds that Jack Valenti, president of the Motion Picture Association of America, is considering the SA sub-rating as a parents' advisory for a 36-month evaluation period.

Sexual sobriety

VICTORIA — Sexaholics Anonymous (SA), is the latest spin-off group of Alcoholics Anonymous. A pamphlet published by SA explains that instead of being at the mercy of the bottle, SA members admit they are "addicted to sex with self, promiscuity, adultery, dependency relationships, and fantasy." The program's primary purpose, says *The Toronto Star*, is to encourage sexual sobriety among its members. The SA group here is one of several across North America.

Flash and sniff

ANAHEIM, Cal — United States police may soon sniff out suspected drunk drivers with a flashlight featuring a built-in sensor to detect alcohol on a driver's breath. Researchers have concealed a tiny odor sensor in a bulky flashlight with a digital display on the back, which provides a reading in just 10 to 15 seconds, says *Associated Press*. The device is intended to indicate whether there is enough alcohol on the breath to warrant more comprehensive testing. Widespread use of the flashlight could begin within a year, authorities say.

Smokers lose pay

CAMBRIDGE, Eng — Britain's oldest publishing house is attempting to root out smoking among staff by deducting pay for time spent puffing. Cambridge University Press here said the policy was invoked following a poll of its 200 employees. The majority didn't want smoking in the building, says *The Toronto Star*. Smokers must now go to a special room to have a cigarette and are not paid for the time they spend there. Several staffers have quit — smoking that is.

Deadly drugs

WASHINGTON — The United States Food and Drug Administration here has the right to refuse to ensure that injections used to execute convicts are safe and effective. In a unanimous ruling, the US Supreme Court overturned an earlier decision which had blocked states from using lethal drugs until they were tested by the FDA, says the *Medical Post*. The FDA has rejected appeals by prisoners in Texas and Oklahoma to review the drugs to see if they produce a quick and painless death.

Stocking the drug will be dangerous, they say

Pharmacists are angry about heroin

By Maureen Brosnahan

WINNIPEG — Most neighborhood pharmacists are unwilling to stock heroin in their stores once it becomes available for medical use this fall, says the president of the Canadian Association of Community Pharmacists.

Morna Cook, a Winnipeg pharmacist and president of the national group, said an informal poll conducted among some members indicates that the majority are concerned with the security risk involved in stocking the drug, especially with the rise in recent years of drug store robberies.

"When you're looking down the snub-nose of a .45 for Valium (diazepam), you're not likely to bring heroin in," Mrs Cook told **The Journal.**

She said pharmacists are reticent about stocking the drug because it could make them the target for desperate drug addicts and pushers.

As well, she said, it's expected that so few patients will be administered the drug that it would not benefit pharmacists to keep a quantity on hand.

Last December, Canadian Health Minister Jake Epp announced that the government would allow the legalized use of heroin to treat pain in terminally-ill patients. Earlier this summer, he said the drug will be available in Canada by October.

A spokesman for Mr Epp in Ottawa said federal health officials are still working out the details on the protocol for heroin use. These will likely be released this month.

The Canadian Medical Association supports the medical use of heroin, while the Canadian Pharmaceutical Association has objected to it, saying that other pain-killing drugs are just as effective when administered properly.

Epp: public deceived?

Donna Shaw, executive director of the Canadian Society of Hospital Pharmacists, said in an interview from Toronto that many hospitals have indicated that they are not interested in using the drug.

"I think there are many hospitals that have said, 'we don't want any part of this,' " she said.

"We feel the public has been taken on this," she added. "The public has been left with the idea that this is a great panacea. I think there is going to be a great disappointment."

She said many other pain-killing narcotics already available through prescriptions can ease pain if they are administered properly, on a regular basis.

But, she said, many times doctors try to control terminal cases and other similar pain by prescribing pain-killing drugs as needed, rather than on a regular regime, which is the proper way to ensure pain control.

In Winnipeg, St Boniface General Hospital, the province's second largest teaching hospital, has declared it will not approve the use of the drug on patients.

Other hospitals, including the Brandon General Hospital, have yet to decide whether to approve it, spokesmen said.

Many, including the Health Sciences Centre, Manitoba's largest teaching hospital, have adopted a wait-and-see attitude and don't expect to take any action to support or reject the drug until later this fall.

Paul Henteleff, head of the palliative care unit at St Boniface, said the decision to reject heroin was made by the hospital's pharmacy and therapeutics committee, based on security problems and the questionable effectiveness of the drug.

Dr Henteleff, who opposes the medical use of heroin, said heroin works the same way to control pain as morphine, which is being used routinely among terminally-ill patients in the hospital.

He said he believes many people have been deceived about the drug and the "trendiness" of its legalized use.

"A lot of people are mistaking it, and think it's a cure for cancer," he said. "That's one of the really frightening things about it."

Dr Henteleff said he knows of only one Winnipeg doctor who openly welcomes the medical use of heroin here and who says he plans to prescribe it to patients.

Psychologist wants phenothiazines banned

BRIGHTON, England — Pharmaceutical companies should be forced to remove phenothiazines from the market because of the high rate of tardive dyskinesia caused in patients, the World Congress on Mental Health here was told.

David Hill, PhD, senior clinical psychologist at Walton Hospital, Chesterfield, England, said studies have shown that approximately 25% of those prescribed the drugs will develop tardive dyskinesia, a form of brain damage which starts with involuntary movements of the tongue and facial muscles. In extreme cases, it can lead to uncontrollable jerking of the arms and legs.

Estimates are that some 150 million people world-wide have been prescribed the drugs, and about 25% (38 million people) will suffer adverse consequences, including irreversible brain damage. It had been estimated in the past that damage occurs only after long-term use, but 14% of those who develop tardive dyskinesia do so within the first year.

Dr Hill acknowledged that many doctors would challenge his conclusions and contend that the side effects should be tolerated because of the grave risk of schizophrenic patients relapsing if the drugs were withdrawn. He does not think that claim valid.

Until the drugs are withdrawn from the market, he said, doctors should tell patients they run the risk of brain damage, and any prescriptions should be for a maximum of two months use.

One of the paradoxes is that if the drugs are withdrawn, the symptoms of tardive dyskinesia get worse. The only way to relieve the symptoms is to increase the drug dosage, and while this would mask side effects, it may cause even worse brain damage.

Research can help therapists and policy makers

(from page 1)

tant role in increasing the tendency to self-administer a drug, ie, in increasing the strength of addiction to it."

Dr Kalant told the conference, sponsored by the International Council on Alcohol and Addictions and hosted by the Alberta Alcohol and Drug Commission: "The successful management of addiction, therefore, requires deliberate measures to extinguish tolerance and physical dependence, and the learning and conditioning factors that contribute to them.

"Simply removing the drug does not eliminate these factors, and prevention of relapse will require the incorporation into treatment programs of specific extinction procedures for the learning and conditioning factors in tolerance and dependence."

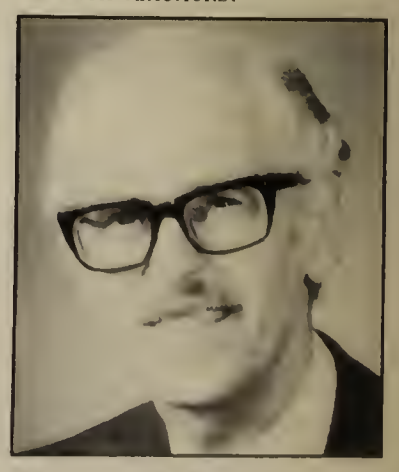
A possible long-term benefit of this research, Dr Kalant said, is that what is learned about the mechanisms of nervous system tolerance is "likely" to be relevant to the mechanisms of learning and memory.

"In that way, tolerance research may contribute to the solution of (learning and memory) problems affecting very large numbers of people who do not suffer from addiction."

Dr Kalant addressed four biomedical research areas in which "important, even outstanding, advances" have been made — the genetics of alcoholism, endogenous opioids and their receptors, tolerance to alcohol and other drugs, and the clinical impact of alcohol consumption on brain and heart disease.

"Each of these fields has yielded recent findings which illustrate important principles in either the theoretical conception or the practical management of alcohol and drug dependence.

"These developments have important present implications and future possibilities with respect to how therapists, educators, and policy makers carry out their functions."



Kalant: implications

ICAA takes on tobacco

(from page 1)

Specific points of concern were the addictive properties of tobacco and the need for addiction agencies to become involved; passive smoking and environmental pollution; the "persistent search" by the multinational tobacco industry for new markets; and the relative strength of those who sell tobacco and those who try to prevent its use.

Of 14 recommendations, four involve policy, seven strategy, and three research.

It's in the policy area that the report will most challenge ICAA.

The report asks ICAA "actively to advocate the adoption of comprehensive tobacco control, prevention, and cessation measures, both nationally and internationally."

Said Mr Archibald, who was re-elected ICAA president for another term at the Congress: "Some of the recommendations have very fundamental policy implications for ICAA. For example, becoming more active in advocacy, which is defined as political.

"Certainly, tobacco is now very much part of our interest. Our major point of entry — the area that others are not so concerned with — is the whole area of addiction to tobacco. That relates directly to ICAA."

NEWS

'It wasn't long before I was in deep trouble'

My story shows female alcoholics' needs: Ford

By Elda Hauschildt

CALGARY — A composite picture of the female alcoholic patient — 44 years old, married, employed outside the home — has been drawn up by staff at the Betty Ford Center in California.

"Alcohol is her drug of choice, although she abuses other drugs — perhaps cocaine," Betty Ford, wife of former United States president Gerald Ford, told more than 400 people attending a Focus on Women luncheon at the 34th International Congress on Alcoholism and Drug Dependence here.

"She has sought some professional counselling within the six months prior to her admission. She has also recently received treatment from a physician for a physical condition that is directly related to her alcoholism."

Mrs Ford's composite was based on data gathered "over the past months" at her two year-old treatment unit, where 49% of the patients are women.

"Since alcoholism is a disease that affects the whole family, our staff encourages participation of the spouse and other family members in the treatment process of our patient," Mrs Ford said.

"But, for our composite female patient, it is doubtful her family will make the commitment to attend the family program." Women married to alcoholics stay with their husbands nine out of 10 times; on the other hand, Mrs Ford said, "when the woman is the alcoholic, the numbers are reversed."

Women patients also have slightly longer stays in treatment, "another indication of their greater physical and emotional needs."

Recognizing these needs, and the "spiritual difference that impacts on the woman alcoholic," is important to treatment, Mrs Ford said.

"For a long time, we as women have lived in these (stereotyped) images of what we should be. When we couldn't achieve everything the role demanded, we were quick to believe there was something wrong with us. Now, we're beginning to see that perhaps the error was not in us, but rather in the stereotype."

Mrs Ford outlined her own recognition of her alcohol and drug dependency seven years ago.

"My intake of prescription drugs went up — painkillers, muscle relaxers, and sleeping pills. Prescriptions given to me, obviously, by a doctor who was uninformed about drug dependency; a doctor who was, perhaps, intimidated by a former first lady; a doctor who was afraid to say no.

"When I combined the wonderful, relaxing pills with drinking — social, of course — it wasn't long before I found myself in deep trouble."

It was trouble she was unaware of, because "the denial I had for my disease was intact."

After her family intervened, and she was treated at Long Beach Naval Hospital, Mrs Ford recovered, and has become a spokeswoman for separate treatment programs for women with chemical dependencies.

"Alcoholism is a progressive disease, and for women it progresses more rapidly. This is called telescoping.

"Women alcoholics often have that added boost to their drinking that comes in the form of pills," Mrs Ford said, noting it is estimated 80% of female alcoholics also use one or more prescription drugs.

Jellinek award goes to two FAS scientists

CALGARY — A physician and a scientist whose work "initiated the accumulation of knowledge" on Fetal Alcohol Syndrome (FAS), are joint winners of the 1985 Jellinek Memorial Award.

The scientific contributions of Ann P. Streissguth, PhD, of Seattle, and Paul Lemoine, MD, of Nantes, France, "can be measured in the most valued of human resources — the health of our infants," said the citation.

Dr Streissguth is a professor, department of psychiatry and behavioral science, School of Medicine, University of Washington; Dr Lemoine is a pediatrician, professor of child care at the Nursing School of Nantes, and honorary physician to Nantes hospitals.

Medals bearing the profile of E. M. Jellinek — "one of the founding fathers of the scientific approach to the study of alcohol problems" — and cash awards of $3,000 each were presented here at the 34th International Congress on Alcoholism and Drug Dependence, by H. David Archibald.

Mr Archibald, president of the International Council on Alcohol and Addictions, is also president of the Jellinek Memorial Fund. Winners of the award are selected each year by an independent, international selection committee appointed by the board of directors.

Role-model families can aid substance abusers

By Harvey McConnell

WASHINGTON — An "adopt-a-family" program by which a substance-abusing family is sponsored and befriended by a normal volunteer family is being developed at the University of Utah.

Karol Kumpfer, PhD, said the idea has grown out of an ongoing study with colleague Joseph DeMarsh, PhD, into the children of drug-abusing parents. She gave preliminary findings at a seminar here held by the United States Alcohol, Drug Abuse and Mental Health Administration.

Dr Kumpfer said while studies indicate children of alcohol-abusing parents run a higher risk of becoming alcohol abusers, there is little empirical data about children of drug abusers or their special characteristics or needs. Much of what is known was gathered in a 1972 Canadian study (Smart and Fejer) of 2,000 families.

The present pilot study is of 60 drug-abusing families recruited from a methadone maintenance clinic and an alcohol and drug treatment unit of a mental health centre in the Salt Lake City area. Control families are taken from census data and from high, medium, and low-income levels. Researchers plan eventually to involve 260 families.

The aim is to determine the impact of substance-abusing parents on the attitudes and behaviors of children aged six to 12 years, Dr Kumpfer said, and on the factors which differentiate normal and drug-abusing families.

They have found significantly more of the six to 12 year olds in substance-abusing families said they will probably use drugs, although not alcohol or tobacco, when they are older. In contrast, children in normal families said they will more likely use tobacco or alcohol.

Children of drug-abusing parents feel more socially isolated, have fewer chances to play than other children, fewer friends to tell secrets to, and they bring fewer friends home.

According to drug-abusing parents, their children are more disobedient at both home and in school, they are late or miss school more often than control children, and they have more academic problems.

Dr Kumpfer said they found more of the drug-abusing parents come from families where their own parents used drugs and abused prescription drugs. "Our data indicate that the mother's drug use has a particularly significant correlation with the offspring's use of drugs."

Drug-abusing parents spend less time with their children, and "we believe a great deal of emotional neglect is going on."

Drug-abusing parents seem more involved in their own needs to get drugs than in their home life, and there are many problems, including family fights and disobedient children, which can be caused by this lack of responsibility.

Dr Kumpfer said drug-abusing parents have more depression and stress than parents of control families.

She said: "Until we begin to give special attention to high-risk children, I believe we will never make significant headway against drug abuse."

The affected children need to be taught a number of social skills, but as many parents have themselves never been taught these skills, there is a need for volunteer models.

This led to the idea of an "adopt-a-family" program in which normal volunteer families will work long-term with matched drug-abusing families. The researchers are now trying to develop such a program within the local community.

New CAF executive

CALGARY — Tom Doyle of St John's, Newfoundland, is the new president of the Canadian Addictions Foundation (CAF). Mr Doyle was elected at the foundation's annual general meeting, held in conjunction with the 34th International Congress on Alcoholism and Drug Dependence.

A former provincial cabinet minister, Mr Doyle is a past president of Newfoundland's Alcohol/Drug Foundation, and spearheaded the planning and research which lead to the establishment of the Newfoundland and Labrador Alcohol and Drug Commission in 1982.

Elected to the executive with Mr Doyle were: Dr Paul Whitehead of London, vice-president; Colleen Allan of Winnipeg, secretary; Joseph MacIntyre of Fredericton, treasurer; and, Don Baran of Montreal.

CAF directors for 1985-86 include: Ray Gerry, Regina; Lloyd Carr, Yellowknife; Peter Mitchell, St Andrews, NB; Maurice Prevost, Montreal; Lt-Col Jacques Roy, MD, Ottawa; Henry Schankula, Toronto; Jim Stimson, Vancouver; Bernie Boyle, Ottawa; Irene Brown, Richmond, BC; Capt John Moore, Winnipeg; Brigitte Neumann, Halifax; and, Ken Fraser, Ottawa (past president).

Parents should discuss commercials with kids

Tight economy forces boost in drink advertising

By Betty Lou Lee

HAMILTON — Liquor consumption in Canada has dropped 20% since 1981, and the industry has laid off 20% of its workers in that time, says a spokeswoman for the Association of Canadian Distillers.

Kay Kendall, director of communications and public relations, says prices have risen 50% since 1981 because of "enormous tax increases," but the distillers get only 16% of the sale price.

Ms Kendall took part in a panel on substance abuse and advertising at the 26th annual Institute of Addiction Studies, at McMaster University here.

Distillers in Canada and the United States voluntarily limit their advertising to print media, and have reduced their ads because of falling profits, she said.

"Our ads just lie there in print, they don't jump up and down. But our industry is castigated because of the beer ads on TV."

But, if liquor advertising is down, alcohol advertising isn't.

There's been a 400% increase in advertisements submitted for approval to the Liquor Licence Board of Ontario in the past few years, said Gerry Conroy, its manager for advertising and special projects.

It is now averaging 195 submissions for print ads, and 130 commercials for radio and television, per month.

Thirty percent are rejected, 20% are approved on condition that certain changes be made, and 50% are approved, he said.

Prohibited are endorsements by well-known people, consumption combined with the operation of any vehicle, immoderate use, consumption that is directly or indirectly related to minors, and "lifestyle" advertisements, although Mr Conroy said the latter couldn't be defined.

He said later that Carling O'Keefe Brewery in Quebec is questioning that province's regulations prohibiting celebrity endorsements.

Toronto journalist Sidney Katz, the panel moderator, said the pressure to advertise is "probably greater than ever before" because the public has fewer disposable dollars to spend on alcohol. There is also a "new temperance" movement, there is more interest in fitness and health, and pressure groups to reduce impaired driving have had a "tremendous impact .... One such group is SMART, Stop Merchandising Alcohol on Radio and TV."

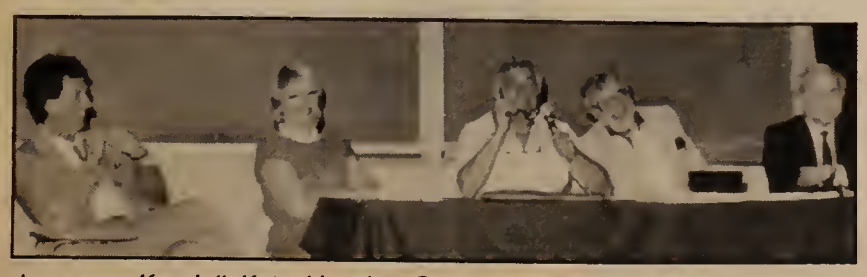
Jack Livesley, a host on TV Ontario, which does not carry commercials, suggested parents discuss commercials of all types with their children, pointing out how the use of color, sound, closeups, and stereotyping can be used to manipulate.

Peter Loranger, PhD, head of development and production in the education resources division of the Addiction Research Foundation of Ontario, showed a new film with a similar theme.

Never Listen to a Bottle is aimed at 8 to 10 year olds, and its messages are: "not everything said on TV is necessarily true, brewers and distillers have a right to ask you to try their product, but if you don't, that's fine . . . and be critical of what you see."

Ms Kendall said the film stereotyped: the abusing puppet drank liquor, the moderate puppet drank beer.

She was the only representative of the alcohol industry on the panel: Institute organizers were unable to get a brewery spokesman.



Loranger, Kendall, Katz, Livesley, Conroy (left to right): ads 'just lie there'

THE JOURNAL
— next month —

- *Alcohol and Drug Problems Association of North America*
- *More from the ICAA 34th Congress*

NEWS

RESEARCH UPDATE

Anti-smoking intervention in pregnancy

Women who experience problems early in pregnancy appear to be more receptive to programs aimed at smoking cessation. This is what University of Maryland researchers found when they evaluated results of an earlier study which found a 92-gram difference between infants born to women who had anti-smoking intervention and those born to women in a control group. The three researchers from the department of epidemiology and preventive medicine of the school of medicine looked at the interaction between maternal characteristics and intervention for 935 pregnant smokers in the Maternal Smoking and Infant Birth Weight Trial. Statistical analysis found that the effect of intervention on smoking cessation was significantly greater for women who experienced problems such as high blood pressure or urinary tract infection early in pregnancy. The beneficial effect of intervention was found to decrease with the age of the mother and number of previous low-birth-weight infants, but increased with previous fetal loss. The researchers said that the existence of serious problems early in pregnancy "apparently . . . served as a catalyst which promoted a larger intervention effect than that achieved for women without the problems," and this could be used to identify women more likely to benefit from an intervention program.
American Journal of Epidemiology, July 1985, v.122:135-148.

Dangers of high-flying passengers

Airline cabin crews should become more aware of how to deal with drug abuse problems among passengers, two physicians examining the situation have recommended. John Lyman, MD, and Stanley Mohler, MD, of the emergency and community medicine departments of Wright State University School of Medicine, Dayton, Ohio, stated that while airlines are unwilling to give precise statistics, a significant number of passengers experience in-flight complications resulting from narcotic addiction. They indicated problems involving heroin, amphetamine, and hallucinogen abuse have arisen because of the involvement of the more affluent members of society with these drugs. Noting that flight attendants will inevitably encounter such passengers, the physicians recommend that crews learn to identify and categorize drug abuse problems. "Flight attendants should be trained to remain calm when faced with a drug-influenced passenger, and to use onboard resources, including passenger resources, such as travelling law enforcement officers or physicians," they said.
Aviation, Space, and Environmental Medicine, May 1985, v.56:451-456

Drug dispensing in hospitals

A United States air force medical centre has succeeded in developing a method for controlling access to narcotic drugs among anesthesia personnel — a group which is particularly susceptible to substance abuse because of drug accessibility. Researchers at Wilford Hall USAF Medical Center, Lackland AFB, Texas, a centralized dispensary for use by anesthesia residents, nurse anesthetists, and teaching staff did little to control unauthorized access to the drugs. The new system they developed uses individual narcotic boxes distributed to each resident. Each drug transaction is recorded and checked for accuracy by a narcotics control officer in the hospital. The transaction forms are entered into a computerized system and analyzed weekly for signs of significant overuse. Residents who cannot explain legitimately the alteration in their drug usage are comprehensively audited. Drugs are issued daily to those residents who administer anesthesia. After the first 13 months of using the system, researchers report nobody had been identified as a drug abuser, and acceptance of the system — after initial resistance — has been good. They say the system is cost-effective for monitoring dispensing and use.
Journal of the American Medical Association, June 7, 1985, v.253:3133-3137

Pat Rich

Amateur athletes chase competitive edge

Growth drug hitting black market

By Betty Lou Lee

Drug regulations, tests: Olympic gold worth millions of dollars

HAMILTON — Human growth hormone, produced synthetically by bacteria, is the newest substance being used by athletes to boost performance.

"It's now on the black market, and some body builders are using it," said Duncan MacDougall, PhD, professor of physical education at McMaster University here. "The jury is still out on its effectiveness and hazards. We don't know if it's being given to promising young athletes."

Human growth hormone is used medically to treat dwarfism. Until a few years ago, its only source was human donors or cadavers. Normally, its production by the pituitary gland peaks with the major growth spurt at puberty, then no longer causes growth.

In spite of stricter "anti-doping" regulations and tests in amateur sports, "drug use is not decreasing," said Dr MacDougall, a physiologist who does research in skeletal muscle physiology.

"As long as sports has such a high profile, and athletes can get hundreds of thousands of dollars for winning and endorsing products, athletes are going to keep attempting to get that little edge by using drugs."

He cited a United States survey of 20-year-old amateur athletes in which they were asked if they would take a substance that would ensure them a gold medal, if it might have bad effects that would appear when they were more than 40 years old. All of them said they would. Asked if they would take a substance if it would kill them after 40 years of age, 50% said they would.

For a good-looking, "marketable" athlete, an Olympic gold medal can be worth as much as $5 million in endorsements, Dr MacDougall told the 26th annual Institute for Addiction Studies held at McMaster University here by Alcohol and Drug Concerns, Inc. A silver medal winner doesn't have this opportunity, even though his or her time is only milliseconds from the gold.

Blood boosting, or blood doping can increase the ability to consume oxygen by 5%, "and that 5% is the difference between first and 10th place in a 10,000 metre final."

Blood boosting involves the removal of a litre of blood about a month before competition, keeping the red cells in frozen storage, and reinfusing them just before a meet, when the body has already restored its cell level.

This can't be detected by existing tests, and since no foreign substance is involved, there are legal problems with banning it.

"As athletes see it, only those substances tested for are illegal," said Dr MacDougall.

Since some studies indicate blood boosting increases the time to exhaustion by 35%, it is most popular with marathoners and long-distance cyclists. The only known dangers are a slight, transient increase in blood pressure, infection from the complications of reinfusion, or mixing up the blood of two athletes.

Anabolic steroids to build musele are banned in amateur sport, but are still widely used, Dr MacDougall said. The rate is probably 99% among male professional body builders and increasing from the 10% among women a few years ago because the trend is away from the "dancer's physique" and toward more muscle.

In his own work with muscle cells of body-builders who have used steroids for 10 years, Dr MacDougall is finding changes similar to those found in muscular dystrophy.

In men, the steroids can result in breasts so enlarged they require surgery. In women, they affect menstrual cycles, can increase facial hair and the size of the clitoris, lower the voice, and cause acne.

In adolescents whose long bones have not completed their growth, they can prematurely close the epiphyses, stunting stature.

The steroids are prescription drugs in North America but not in Mexico or many other countries, and there is a thriving black market in them, Dr MacDougall said. But, almost one-third of North American athletes get them from physicians who rationalize that they will get the drugs anyway and prefer to monitor them for possible effects like changes in liver enzymes.

Massive doses of bicarbonate tablets just before a short-term event are being used for their buffering capacity, to forestall the build-up of lactic acid in muscle during intense exercise. Research at McMaster and York University in Toronto showed there was "significant improvement" among 400-metre runners with this loading.

Extreme diarrhea and cramps may be a side-effect, but no long-lasting effects are known, and athletes aren't tested for bicarbonate loading.

Double-blind studies of amphetamines show no effects on time to exhaustion or all-out performance, and athletes are beginning to know this, said Dr MacDougall.

Their easy detection in urine is probably eutting their use in competition, but they are being used "to a great extent during training to log extra training miles."

Some professional athletes in eontact sports feel amphetamines make them more aggressive. "Until a few years ago, team doctors in the Canadian Football League handed them out."

Caffeine loading for long-term events like marathons and cross-country skiing is used to mobilize stored fat into free fatty acids in the blood. The use of fatty acids as an energy source spares the glycogen for the muscle, so there is still some there for the finish of the event. High concentrations of caffeine can be detected in urine.

Dr MacDougall said the budget for anti-doping tests at the 1984 Los Angeles Olympics was higher than the entire cost of the Mexican Olympics.

An oath is an oath is an oath — except

By Wayne Howell

The United States currently spends approximately $1 billion a year on agents and para-military hardware to stop the flow of illicit drugs into the country.

Recently, Attorney-General Edwin Meese announced that another $100 million is to be dropped into the "anti-drug" pot. The money is to be used to purchase and radar-equip 16 military surplus airplanes, which will fly out of Panama and other locales in an attempt to interdict drug-smuggling aircraft and ships; to finance a scheme whereby the US military will train and arm host-country locals as "drug commandos" to attack production of illicit drug crops; and, to further the integration of the DEA (Drug Enforcement Administration) into the FBI (Federal Bureau of Investigation).

Despite the $1 billion-a-year price tag, the DEA always claims that it is only confiscating approximately 10% of the drugs that come into the country. One wonders what good another $100 million is going to do.

On the basis of past performance, this should push up the success rate by a meagre 1%. It is almost enough to make one think that, well, maybe, just maybe, all this "drug-busting" business has another side to it, a darker side. Well, rest assured. I have obtained a copy of the DEA Code of Ethics, to which all DEA agents swear an oath of fealty. I reproduce it here to assure all reasonable people that there is nothing to be feared.

The DEA Code of Ethics:
"I do solemnly swear by whatever I hold most sacred:

That into whatsoever sovereign nation I shall enter, it shall be for the sole purpose of identifying and discouraging those people who traffic in narcotics and other noxious substances. If, during my sojourn in another nation, my drug-enforcement duties cause me to be associated with men of various political persuasions, that whatsoever I shall see, or hear, of the lives of political men will be kept inviolably secret. I forswear this oath only when the information which I inadvertently come to possess is a clear threat to national security, such as learning that a school principal does not believe in the Monroe Doctrine, and a reputable sister-agency such as the FBI, the CIA, US Military Intelligence, or the political or military intelligence arm of my host country is desirous of receiving such information.

That when, in the course of my duties in a host country, I have occasion to arm cohorts of men with US military equipment and train them to attack the producers of illicit drug crops, I shall be ever vigilant that the leaders of these armed cadres are honorable men exclusively concerned with the drug problem and no other — men who have no aspirations of their own, other than the extirpation of narcotic foliage. I forswear this oath only in the case of a clear threat to the integrity of the continental US, as in the case of a town which has elected a Marxist mayor.

That when, in the course of my drug spy-plane duties, fickle Central American winds blow my craft off course, so that I should innocently find myself overflying a sovereign nation and inadvertently picking up — either through radar or other sophisticated electronic means — military and political intelligence of a confidential nature, I shall keep such information inviolably secret.

I forswear this oath only if the nation unintentionally overflown is a clear military threat to the US way of life, as identified in press conferences by the President of the US."

Ear, nose, throat symptoms reported

Sidestream smoke hazardous: epidemiologist

By Rhonda Birenbaum

OTTAWA — There may be no safe level of involuntary exposure to cigarette smoke, a Health and Welfare Canada epidemiologist says.

"Non-smokers located close to smokers (within three metres) are exposed to 50 times more formaldehyde and acrolein than smokers," Don Wigle, MD, chief of the non-communicable disease division, bureau of epidemiology, told a Canadian Lung Association meeting here. "There is also 10 times more pyridine, three times more hydrazine, and eight times more carbon dioxide in sidestream smoke."

As well, non-smokers involuntarily exposed to tobacco smoke inhale 1.3 to 2 times more particles than do smokers, said Dr Wigle.

The high concentration of chemicals in sidestream smoke results from the way cigarettes burn, Dr Wigle explained.

Most of the toxic chemicals in tobacco smoke form in the zone just behind the burning area. A puff on the cigarette raises the burning temperature enough to burn off many of the chemicals in the mainstream smoke. The temperature of the burning tip of a cigarette is lower, resulting in incomplete combustion of the chemicals.

In reviewing health effects of tobacco smoke on non-smokers, Dr Wigle found involuntary exposure to tobacco smoke resulted in 12 physiological changes and symptoms in healthy adults. He estimates close to 90% of Canadians are likely to be chronically exposed to tobacco smoke at home, at work, or both.

"The symptoms reported by non-smokers include eye irritation, nasal congestion, headache, cough, sore throat, hoarseness, nausea, dizziness, general annoyance, loss of appetite, and tingling fingers," he said.

"Brief exposure of non-smoking adults to high concentrations of tobacco smoke also results in a significant impairment of lung function."

Dr Wigle said more than 20% of Canadians have a health condition that is aggravated by exposure to tobacco smoke, including heart disease, respiratory disease, emphysema, asthma, and hay fever. And, most non-smokers exposed to tobacco smoke have nicotine in their body fluids for most of their lives. (Nicotine is found only in tobacco.)

Dr Wigle said authoritative groups don't all agree on the cancer-causing natures of all the chemicals in smoke. But, each has concluded involuntary exposure to tobacco smoke is a health hazard to be avoided. They include the United States Surgeon General's Office, the US National Research Council, the Ontario Council of Health's Task Force on Smoking, and the Ontario Medical Association.

"Existing air-quality standards for workplaces do not directly specify an acceptable level for tobacco smoke," Dr Wigle said. "However, for several of the components in tobacco smoke, the recommended exposure limit is either zero or not assigned, suggesting there may not be a safe level for involuntary exposure to tobacco smoke."

BC okays beer, wine shops

VICTORIA — The provincial government here has given hotels and pubs the go-ahead to open stores selling British Columbia beer, wine, and cider.

New regulations announced by Consumer and Corporate Affairs Minister Jim Hewitt will allow the stores to sell refrigerated beverages at prices at or near those charged in the government-run liquor stores that handle virtually all retail liquor sales.

The new stores will sell only BC products and will be required to carry a "representative selection" of products.

Previously, off-premise retail sales were limited to beer, at a steep markup that discouraged customers. In addition, BC wineries have been allowed to operate winery shops selling their own products.

GILBERT

'The risks are relatively small, but . . . greater than the risks of death as a result of pregnancy, abortion, or firearm accidents.'

Passive smoking: I

By Richard Gilbert

In this column, I am going to assess some of the material on passive smoking published since my brief review of the topic in a column on smoking in the workplace in March, 1984. Next month, I will write about what has been happening in Ontario generally regarding the regulation of public smoking, and in Toronto in particular on the issue of smoking in the workplace.

After some years of caution, I concluded in last year's column that "the balance of the evidence points to a harmful effect of second-hand smoke on healthy adults." Studies published during 1983 had, in my view, tipped the scales. Other reviewers have not been so persuaded, including the influential but anonymous writers of an article published in *Consumer Reports* in February this year, and their advisers.

ETS — a blend

Second-hand tobacco smoke is now being referred to in the medical literature as ETS — environmental tobacco smoke. A French researcher has made the distinction between the primary smoke inhaled by smokers (also known as mainstream smoke), the secondary smoke that rises from a burning cigarette (also known as sidestream smoke), and the tertiary smoke exhaled by smokers. ETS is a blend of secondary and tertiary smoke.

Consumer Reports concluded in February, 1985 much as I did before 1983: ETS causes discomfort to a lot of people, worsens disease in many who are already ill, and causes disease in some healthy children. The question of whether chronic exposure to ETS is a cause of disease in healthy adults, particularly of lung cancer, remains unresolved.

The main argument in the article is this: A Japanese study published in the *New England Journal of Medicine* in September, 1984, had shown that even heavy chronic exposure to ETS — more than a pack a day smoked at home and more than six smokers per room at work — was equivalent to no more than one or two cigarettes a day. A major review by the United States National Cancer Institute in the 1970s had concluded that the average person could smoke two cigarettes a day without *measurably* increasing mortality risk above that of a non-smoker.

The equivalence between heavy exposure to ETS and smoking one or two cigarettes a day was estimated by measuring the levels of cotinine in the urine of non-smokers, and comparing them with the levels found in smokers of differing numbers of cigarettes. Cotinine is the major metabolite of nicotine in blood and urine. It appears in the body only as a result of the metabolism of nicotine. Its concentration in urine is roughly proportional to the amount smoked.

Cotinine marker

The Japanese researchers found that heavy exposure to ETS was associated with an average level of 1.56 micrograms of cotinine per milligram of creatine (the standard measure) compared with the level of 1.71 micrograms found for smokers of less than three cigarettes a day.

The equivalence on which *Consumer Reports* based its argument is valid to the extent that cotinine is a marker for the cancer-causing elements of cigarette smoke as well as for nicotine. But, tobacco smoke's cancer-causing ability is more related to the amount of particular matter (tar) in the smoke than to the amount of nicotine. If sidestream smoke contains relatively more tar than mainstream smoke, comparisons based on cotinine will underestimate how much smoking is equivalent to a given level of ETS exposure.

Various studies have shown that tar concentrations are relatively higher in ETS than in mainstream smoke. Most significant is a Canadian finding that tar/nicotine ratios for 15 brands of cigarette were, on average, 140% higher for sidestream than for mainstream smoke. Thus, the cigarette consumption equivalent to heavy ETS exposure should be 140% higher than that assumed by *Consumer Reports*, ie, three to five cigarettes a day rather than one or two. As *Consumer Reports* noted, the minimum risk level for throat cancer is 2½ cigarettes a day for the average person.

Raised equivalence

Another factor may raise the equivalence even higher. Mainstream smoke is more filtered than sidestream smoke — by the tube of tobacco and by the filter. It is also produced at the higher temperatures caused by the smoker's draw, meaning that it comes from tobacco that is burnt more completely. As a result, sidestream smoke contains a higher proportion of carcinogens and potential carcinogens — 50 times more in the case of N-nitrosodimethylamine which, according to the International Agency for Research on Cancer, "produces cancer in all animal species in which it has been tested and does so by various exposure routes, including inhalation, and after single doses."

Thus, proper application of the *Consumer Reports* argument indicates that heavy exposure to ETS should be equivalent to at least three and maybe many more cigarettes a day, and that such heavy exposure should raise the mortality risk.

I should add that although the National Cancer Institute had set the minimum level of consumption at which risk of cancer is measurably elevated as being 2½ cigarettes a day, other authorities have offered lower figures based on different methods. Extrapolation from data on mortality risk from high consumption levels has produced an estimate that the "virtually safe dose" is 0.005 cigarettes a day. Almost every non-smoker in our society is exposed to the equivalent of more than this amount, no matter which method of estimating equivalence is chosen.

The main evidence as to whether the mortality risk is actually raised by ETS exposure has come from studies in which spouses of smokers and non-smokers have been compared for mortality from lung cancer. Most of these studies have shown an effect, although *Consumer Reports* chose to be guided by some that did not.

Spouse effect

A critical factor in these spouse studies seems to be whether the spouses work and are thus exposed to high ETS levels away from home. Typically, workplace exposure is about three times that from a smoking spouse. Thus, studies of populations where it is common for both spouses to work may not produce clear results because the "spouse effect" may be overwhelmed by the "workplace effect."

A current controversy in the literature concerns the extent to which the workplace effect swamps the spouse effect. The matter is made more complex by evidence that non-smokers with smoking spouses are exposed on average to more ETS outside the home than those with non-smoking spouses, possibly because the smokers "train" their spouses to ignore the smoke. This factor would tend to exaggerate the spouse effect when workplace smoking is not taken into account.

Similar risks

A further complication comes with evidence that mortality risk is related to the number of smokers at home. In this study, reported in *The Lancet* in February, the researchers found that having just one household member who smoked did not appear to elevate the risk of cancer significantly, but having two or more smokers at home did. This finding applied to both smoking and non-smoking patients. Thus, having only the spouse smoking may not on average create a sufficiently smoky atmosphere to cause disease.

We cannot be certain that chronic heavy exposure to ETS causes disease in healthy adults. (For that matter, nor are we certain that smoking itself is a cause of disease.) But, in my view, the conclusion that ETS is harmful continues to be reasonable. The risks are relatively small, but they are similar to those for drowning and accidental falls, and greater than the risks of death as a result of pregnancy, abortion, or firearm accidents.

Double standard

James Repace of the US Environmental Protection Agency, who made these comparisons last year, has estimated that between 500 and 5,000 lung-cancer deaths are caused each year in the US by ETS. Mr Repace has drawn attention to the double standard in the judgement of outdoor and industrial emissions on the one hand and indoor cigarette-generated pollution on the other.

Mr Repace is the foremost advocate for ETS-free air. He has powerful allies in Canada, not only the Toronto-based Non-Smokers' Rights Association, which has produced an excellent book, *Smoke in the Workplace*, but also in the federal government. A 1984 Health and Welfare Canada report by Neil Collishaw and two others concluded that ". . . consequences of long-term exposure [to ETS] include decreased lung function and lung cancer . . . there may not be a 'safe' level for such exposure."

EDITOR
Anne MacLennan

PRODUCTION EDITOR
Terri Etherington

CONTRIBUTING EDITORS
Joan Hollobon (Toronto)
Karin Maltby (Toronto)
Harvey McConnell (Washington)

CONSULTANTS
Dr Oriana Josseau Kalant (Science)
Robert Solomon (Law)

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

CORRESPONDENTS
John Carroll (New Brunswick)
Maureen Brosnahan (Winnipeg)
John Dornberg (Munich)
Tom Land (London)
Betty Lou Lee (Hamilton)
Alan Massam (London)
Lachlan MacQuarrie (Hong Kong)
Jean McCann (Cleveland)
Pat McCarthy (New Zealand)
David Milne (Toledo)
Tim Padmore (Vancouver)
Lynn Payer (New York)

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Backgrounder

ICAA at one hundred — the century in review

In 1885, in Antwerp, Belgium, 560 people from a handful of countries met to discuss problems associated with alcohol abuse.

In Calgary last month, the International Council on Alcohol and Addictions (ICAA), as it is now known, held its centennial Congress — the 34th International Congress on Alcoholism and Drug Dependence.

A review of the Congresses between 1885 and 1985 is also a capsule history of the international addictions field. The following report, excerpted with permission from the ICAA News *special centennial Congress issue, captures the gradually-emerging issues of the field in its first century, and reflects the complexities as it stands on the threshold of its second.*

The Editor

Antwerp, 1885
The first Congress was titled the Antwerp International Meeting Against the Abuse of Alcoholic Beverages.

Subjects included:
- the influence of various kinds of temperance societies on criminality, mortality, and the consumption of alcohol; and,
- the work of coffee houses in England.

Zurich, 1887
President of the committee of organization was Professor Auguste Forel, psychiatrist, and a pioneer in the treatment of alcoholics. Dr Forel's involvement with the Congresses continued through the 1920s; he was also president at the 1907 Congress in Stockholm during which the International Bureau against Alcoholism (the forerunner of ICAA) was created.

Oslo, 1890
Oslo (then Christiana) hosted the Third International Congress Against the Use of Alcoholic Beverages in 1890. At the initiative of delegates from England, Finland, and Switzerland, the establishment of an International Bureau Against Alcoholism was recommended.

Vienna, 1904
The Congress here carried the new title of the 8th International Congress Against Alcoholism. This remained unchanged for decades, except at the 1909 and 1934 Congresses, which were *on* and not *against* alcoholism.

Stockholm, 1907
The 11th Congress here marked an important development in the formal establishment of the International Bureau Against Alcoholism (IBAA). The Bureau acted henceforth as permanent secretariat of the International Congresses Against Alcoholism.

Milan, 1913
At this Congress, representatives of 30 countries met for the last time before World War I. Some notable papers were:
- alcohol in the Balkan Wars;
- emigration and alcohol; and,
- influences of the women's vote on alcohol consumption.

Tartu, 1926
Dr Hercod, writing in the *British Journal of Inebriety*, observed that at this Congress: "The scientific and especially the medical aspects of the alcohol problem occupied a less prominent place. . . . It was thought . . . it would be advisable to emphasize the practical aspects of the international campaign against alcoholism."

Warsaw, 1937
The 1937 Congress took place in Warsaw, but its proceedings were not printed until 1939, in Poland. However, only a few copies had been sent out when Warsaw was bombed, and the warehouse and its contents were destroyed. The only known copy of this work now exists in the ICAA library.

Helsinki, 1939
The 22nd Congress saw its proceedings make it into print despite the war that soon engulfed Europe. Among the speakers at this Congress was Ambassador Tapio Voionmaa, who presented his world-wide statistics on production and consumption of alcoholic beverages. Such a study had never been attempted on such a large scale.

Lucerne, 1948
A historical resolution was passed at this meeting: "The Medical Section of the 23rd International Congress on Alcoholism recognizes alcoholism as a medical, moral, and social problem, and expresses the wish that in every country alcoholism be considered a disease."

Paris, 1952
This Congress was to have an impact on future events in France. Only two years later, alcoholism was recognized as a national problem, and the High Committee of Study and Information on Alcoholism, directly responsible to the prime minister, was set up.

Istanbul, 1956
The Congress in Istanbul, Turkey was small in comparison with others, with only 300 in attendance. However, it attracted new delegates from Asia and Eastern Europe. Special messages of encouragement were received from President Nehru of India and President Eisenhower of the USA.

Stockholm, 1960
This scientifically important Congress brought together scientists and research workers; members of the medical, legal, and teaching professions; those engaged in administration and in the alcohol monopolies, as well as members of the temperance movement.

Washington, 1968
As Seldon Bacon writes in Volume II of the published proceedings of the Washington meeting: "The 28th Congress may be viewed as an attempt to develop a sense of coherent relevance, relationship, and direction for a great variety of groups facing an extraordinary diversity of problems, utilizing the majority of arts, sciences, and philosophies, and possessing programs of almost every type."

Sydney, 1970
This was the first Congress to be held outside Europe and North America. Issues concerning drug dependence were discussed for the first time. This was also the Congress at which the name of the event was changed to the International Congress on Alcoholism and Drug Dependence.

Amsterdam, 1972
By this time, drug abuse had become a truly world-wide phenomenon. In fact, some countries which had been hit particularly hard by widespread drug abuse were already re-examining their strategies, as in one plenary paper entitled: Why Prevention Programs Failed.

Bangkok, 1975
The 31st Congress was the first large-scale conference on alcohol and drugs to be convened on the Asian continent. It attracted 732 participants from 54 countries.

Warsaw, 1978
A special symposium took place on research on endorphins and encephalines. This Congress was noteworthy as an event which brought together participants from both East and West Europe, as well as every other continent of the world.

Tangiers, 1982
This was the first of the Congresses to be held on the African continent.

Calgary, 1985
More than 1,200 people from countries around the globe attended this first ICAA Congress ever in Canada. Hosted by the Alberta Alcohol and Drug Abuse Commission, it featured, for the first time, a special international workshop on the harmful effects of world-wide tobacco use.

The Journal welcomes Letters to the Editor.

Letters bearing the full name and address of sender may be sent to: The Journal, 33 Russell St, Toronto Canada M5S 2S1.

The Journal

PENYE NIA IPO NJIA
WHERE THERE'S A WILL THERE'S A WAY

Women in Nairobi
Backdrop for the future

Increasing abuse of alcohol and other drugs is causing growing concern in The Third World, as it continues to in developed countries. Perhaps not surprisingly, however, in the face of such immediate and overwhelming problems as proverty, drought, and starvation, little was said about it formally during the United Nations Decade for Women Conference, or the overlapping Non Governmental Organizations (NGO) Forum, held in Nairobi, Kenya in July (The Journal, August, July, June, May).

While individual women attending both gatherings spoke readily of their anxiety about the impact of alcohol and other drug use on youth and family life in their countries, in the final consensus document, *Forward Looking Strategies*, only two sentences in one of more than 300 resolutions touched fleetingly on the subject.

Professionals in the addictions and related health fields, particularly those who are women, may deeply regret the lack of acknowledgement of, or attention to, alcohol and other drug-related issues at the meetings.

But, to begin to understand is to begin to be able to help.

The resolution that included the reference to drugs reads as follows: "Efforts should be intensified to eradicate trafficking in drugs and to disseminate information on their ill effects. These should include education programs to promote the proper prescription and informed use of drugs. Efforts should also be strengthened to eliminate all *practices detrimental to the health of women and children.*"

Practices "detrimental to the health of women and children" is a carefully-cloaked reference to such controversial customs as female circumcision.

That resolution itself, but also the meetings, hint at the extreme breadth and depth of the problems that the half of the world's population who are women face. In this first special section, The Journal's JOAN HOLLOBON, contributing editor, reports from the meetings. Her stories reflect the context in which addiction professionals now serve around the world, and in which some may see their past, and others may find their future.

The Editor

Looking to the future: some of the thousands of women who met in Nairobi to review the United Nations Decade for Women — 1975 to 1985 — and to set course for the next

Joan Hollobon

Women in Nairobi

NAIROBI, Kenya — A United Nations report, *The State of the World's Women 1985*, notes: "Thirty years after the United Nations first announced its commitment to equality between men and women in its Charter of 1945, concern over the continuing unequal status of women led to the declaration of 1975 as International Women's Year.

"For the first time in history, the eyes of the world were focused on that half of its population who, by virtue of an accident of birth, perform two-thirds of the world's work, receive one-tenth of its income, and own less than one-hundredth of its property."

Everywhere, in the developed and in the developing world, women work twice as many hours as men, but much of their work is "undervalued, unpaid, and unrecognized," and "the final insult . . . domestic work is looked down on as not being 'real' work at all, because it is unpaid."

In Africa, where women do three-quarters of the agricultural work, much of this, too, is overlooked because it is unpaid — it is just "women's work."

Their work is made immeasurably harder for many African women, and their health eroded, through lack of water. Many must travel miles to fetch water for their families. Some leave at dusk, sleep at the water hole, and return before dawn — this in addition to the usual roles of caring for families and working in the fields.

The World Health Organization estimates that, excluding China, 25% of urban dwellers and 71% of rural people in developing countries lack safe drinking water, while 47% and 87% respectively have no adequate sanitation. "Small wonder that an estimated eight million children die each year of disease that might have been prevented by sufficient clean water from a nearby tap," the UN report says.

In Kenya, many of the nomadic, cattle-raising Masai people in the Rift valley, less than two hours from Nairobi by car, suffer from trachoma, a blinding, bacterial eye infection, which is preventable by washing the eyes daily with even a cupful of water.

For these people, who lost hundreds of cattle this year to drought, a cupful of water is a luxury.

Frequent pregnancies also take a severe toll of women in The Third World. Nearly half of them lack any medical care or trained doctors or midwives to assist at delivery. More than 500,000 women die in childbirth every year in Africa and Asia, three of every 1,000 mothers in Ecuador, and up to 20 per 1,000 in Honduras, the UN report says.

The African birthrate is three times higher than Europe's, and 2.8 times that of North America. With a population growth rate of 3% (50% higher than that of the rest of The Third World), Africa will double its 500 million population within 23 years.

Kenya has almost doubled its population from about 10 million to an estimated 19 million in the past 20 years. Nairobi now has one million people and traffic to rival Manhattan on a bad day.

Illiteracy is gradually being reduced, but it is still worse among women: the UN report says that in 1980, 73% of the world's women, as opposed to 48% of men, were unable to read or write.

Third World people often sacrifice to pay school fees and provide books and school uniforms for their sons. For their sons, it's an investment; but not for their daughters. A visit to a Masai elementary school in the Rift Valley showed one small girl among 20 to 30 boys.

Girls are less likely to get a paid job and, if they marry, will be contributing to another's home anyway.

Add to these problems drought, famine, creeping deserts, cultural changes bringing economic, environmental, and psychological burdens, and it becomes fairly obvious why alcoholism and other drug abuse issues were low priorities at the UN meetings here.

Woman power: United States feminist Betty Friedan (centre left) says United Nations Decade

What then did these two huge gatherings achieve? In terms of instant action, nationally or internationally, probably not much, but, in the long-term, likely a lot.

As Walter McLean, Canada's then-secretary of state, said before the Nairobi conferences, the significance of the UN's 10-year focus on women's issues has been that in every participating country "it has thrown a signal into the bureaucracy" that these issues are important.

This was advanced at Nairobi. Hundreds of proposals for the improvement of women's situations in health, economics, law, employment, housing, and many other areas are now enshrined in the consensus document, endorsed by 157 participating countries.

Attendance at the mid-decade conference in Copenhagen in 1980 led Mr McLean to warn, prior to Nairobi, (**The Journal**, July) that the two overlapping meetings would be totally different in character.

He was concerned that women fired up by enthusiasm at the NGO Forum, where participants were deeply committed to women's issues, might be disappointed and even disillusioned at the political gamesmanship they would witness at the official UN Conference.

Indeed, this happened: women's issues were used as a pretext to drag in the perennial international problems of the Middle East and South Africa simply to score political points.

Even the NGO Forum became politicized, particularly toward the end, with placard wavers, marchers, and propagandists backing opposing views.

One day, for example, two small groups of Iranian women were simultaneously telling different stories about the Khomeini regime.

Two middle-aged exiles in western dress described the horrors visited on women under the present government, while 100 yards away — across the grass — three young women in black chadors, praised the same regime as a protector of women.

Palestinian-Israeli antagonisms disrupted an NGO workshop, until the Kenyan chairman firmly told both groups they were abusing Kenyan hospitality and must take their arguments elsewhere.

Nevertheless, the official UN meeting of governmental delegations drew attention to important issues basic to women — and through them to the whole of society. Finally, the meeting accepted a document that recognized the need for change, even if most of the reforms are likely to take decades rather than years.

The achievements of the unofficial meeting were entirely different.

The NGO Forum was not intended to produce documents and resolutions: it was a gathering, women talking to women. Many hundreds discovered that regardless of race, skin color, nationality, culture, dress, education, language, wealth, or poverty, more common interests and concerns linked than divided them. In a shrinking, nuclear-shadowed world, that alone is not to be sniffed at.

The Forum was an extraordinary event in its size and diversity, and also in the atmosphere of genuine friendliness and co-

Iranian women: praising the Khomeini regime as 'a protector of women'

Drug laws spark petition

NAIROBI — Drugs are becoming a problem in Nigeria, and this country of 90 million people is taking drastic measures.

A poster at the NGO Forum sought signatures on a petition to the Nigerian government to repeal the death sentence passed last March on a 36-year-old mother of three children for possession of cocaine. News reports in the Western press during the conference said three men had been shot, and a 20-year-old woman sentenced to death, for drug possession.

Draconian as these sentences are, many Africans seem to consider them justified.

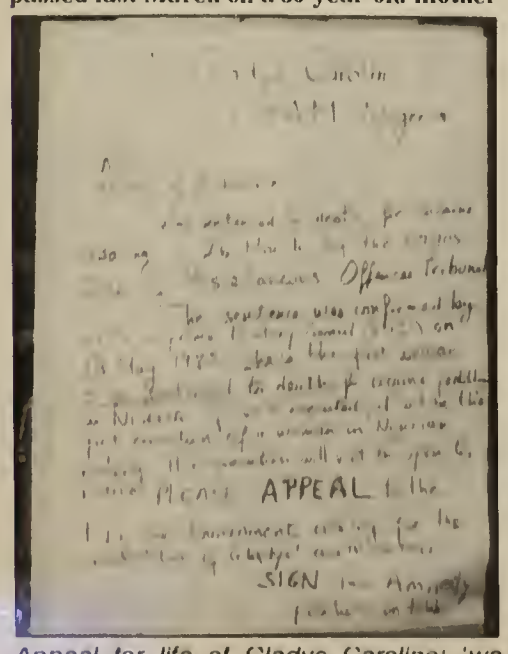
"They know the penalty," one Nigerian woman shrugged. "We just hope it will work. We have held seminars on drugs, supporting the government action."

Simi Johnson, leader of the Nigerian delegation to the UN Conference, told The Journal the Nigerian government is concerned about global drug problems. Cocaine does not originate in Nigeria, and the government is determined to combat the use of Nigeria as a route to transport illicit drugs from countries that "thrive on the export of drugs" to users in Europe or elsewhere.

"We don't want our children to live and die junkies," she said.

Dr Johnson, a dental surgeon, is chairwoman of the Nigerian National Committee on Women and Development. She gave short shrift to concerns about the harshness of death sentences.

"Nigeria has no need to apologize to anyone for her actions. We don't want this in our country," she said.



Appeal for life of Gladys Caroline: 'we don't want our children to die junkies'

Third World concerns —

The influx of thousands of Western women to the UN Decade of Women conferences here led one cynic to assume that "obviously" this was another case of the developed world talking down to developing countries and bringing in all kinds of "foreign and irrelevant" notions.

An NGO workshop on the legal and health status of women showed how, in fact, many workshops quickly focused on Third World issues, and how readily and frankly women from developing countries spoke out even on controversial questions.

The scheduled chairwoman and panel failed to turn up. So, after a short wait, an Australian woman suggested to people in the crowded room they should simply invite speakers from the floor on issues that concerned them.

The discussion began with the legal issues affecting contraception and reproduction, since frequent births affect the health of both mothers and children. The World Fertility Survey in a study in Bangladesh, Nepal, and Pakistan found that babies born within a year of one another were nearly three times as likely to die before their first birthday as babies born four years apart.

Then, discussion turned to the controversial subject of female circumcision. In the past, Westerners opposing female circumcision often have been accused of insensitivity to other cultures, but now many African women are campaigning vigorously against the practice, which is not universal in Africa.

A woman from Cameroon made an impassioned speech calling the practice an

Backdrop for the future

Women is 'a beginning'

peration that prevailed most of the time, lespite the size of the gathering, organizaional frustrations, and the sometimes ranorous political jockeying.

Estimates of numbers vary between 0,000 and 13,000; another 3,000 people atended the UN conference. The Forum was often chaotic, but even this had its advanages: chaos frequently gave birth to sponaneity.

If a workshop leader or panel did not urn up, other women took the initiative. Often, these unstructured meetings were he most rewarding, providing opportunity or spontaneous input from the floor which often was more useful and interesting than nany of the prepared presentations.

Discussions begun in a workshop were often finished in informal groups on the awn outside.

The range of interest at both meetings was almost limitless: the official program was organized under three themes, equality, development, and peace. Scores of specific subjects fell within categories such as health, education, agriculture, trade, commerce, political and legal equality, housing. An example of treatment of a housing subject, for instance, was a discussion on access for women to housing credit-schemes.

Subjects were also considered for their impact on different groups, such as migrant, destitute, disabled, or homeless women.

A few randomly-chosen titles from the NGO Forum workshop program exemplify the breadth of interest there: impact of race, sex, and class on women; women, state power, and politics; working conditions for women in Japan; advancement of women in Africa; women in prison; creative power of youth through spiritual life; community health; traditional practices affecting health of women and children in Africa; women, energy, and environment; domestic violence against women; and, workplace exploitation.

By the time addictions as a subject moves onto the main agenda of such conferences, the need may no longer exist — the range of other problems now is so obviously immense.

A woman from Madagascar at the Nairobi conferences revealed one more problem — one the meetings may help to change.

She refused to give her name because she feared she would get into trouble for telling a foreigner something that might appear to case discredit on her country: she and her country-women had been warned by government officials to be circumspect.

Women from some other countries were at even greater risk; an Iranian woman living in exile in Britain said she feared for the lives of her family if her identity became known.

An Australian delegate, in a letter to the Forum's daily newspaper, *Forum 85*, protested "the surveillance of workshop participants by repressive military regimes."

She said that in a workshop on West Papua a male Indonesian photographer had taken photographs of all the women who spoke on the rights of West Papuan women. "A more sinister practice is the use of representatives of oppressed minorities to speak against their own people," Wendy Poussard wrote.

This had happened at the workshop, but the women were hustled away before they could talk to the refugee West Papuan women, said Ms Poussard.

But, the value of this remarkable gathering was exemplified by the Madagascar woman's attitude. Despite her fears, she spoke openly to this foreign writer.

Meeting so many women from other countries was "wonderful," she said.

"In Madagascar, we are very isolated. This meeting has broken down a lot of my prejudices. I am becoming more open-minded now."

My country is the whole world: thousands of women sign for international peace

Alcoholism hits island's educated

A Madagascar woman attending the NGO forum said alcoholism is increasing among the educated classes in that huge island in the Indian Ocean.

The government is beginning to take action, mainly in the form of organizing meetings and seminars to discuss the dangers of alcohol abuse.

But, she doubts this approach alone will have much impact; the people most in need of educating are the least likely to attend, she said.

Churches in Madagascar speak out against drinking, and alcohol abuse is touched on in schools during health classes. The press is also beginning to address the issue, she said.

Her own husband did not drink until he was in his 40s; a promotion then moved him "up in the world." He thought it "the civilized thing to do," offering guests alcohol.

Now, alcohol has become a problem in their home, but the woman's husband refuses to admit he cannot control his drinking.

While drugs have not yet become a problem, heavy drinking leading to drunken brawls has always been a part of the lifestyle of the coastal people in Madagascar, she told **The Journal.** But, this is not seen as a problem by them or by others.

"It's part of their cultural pattern, it's accepted as their way of life."

Kenyans Leah Oliver Mwakisambi (l), Laura Mugambi: developing human resources

Village woman: water purifiers from earthenware jugs

health, legal issues — dominate discussion

abuse of women endangering health and which has to be stopped."

Gladys Silo Endeley said even in London doctors are paid highly for the surgery. Some African families living in Britain are convinced something terrible will happen to a girl who does not undergo circumcision. She said a woman in Africa came to her in tears; when the woman refused to have her little girl circumcised, her mother and sisters grabbed the child forcibly, and took her to a native doctor who carried out the procedure without anesthetic or sterilized tools.

Ms Endeley said she knew "even educated doctors" who believed in the practice until shown a film of a screaming child undergoing an unanesthetized operation.

No issue is more sensitive, more surrounded by taboos, or more influenced by tradition. Changing ingrained cultural patterns is accomplished only through conflict, and at emotional and psychological cost.

A Kenyan woman said girls who do not go through circumcision fear they will not be married.

"It should be done, otherwise they will be outcasts from their families."

She told of girls who had run away to avoid it, and others who had run away to have the operation. One mother found her daughter sleeping on the floor because she was bleeding so badly from the crude surgery.

The extent of the surgery varies from removal of the clitoris alone to infibulation, in which extensive excision is followed by stitching to leave only a small opening.

A Sudanese physician, Fathia Aimahmoud, MD, said the subsequent severe scarring impedes birth so that an obstetrician cannot assess labor or even determine the size of the woman's pelvis.

The result frequently is a brain-damaged baby or a vesicovaginal fistula, a tear in the wall between bladder and vagina creating urinary incontinence.

These fistulas are common in Africa because of the lack of health and obstetrical care, Dr Aimahmoud said.

Fatma Moma of Nigeria said in Northern Nigeria Moslem girls are married at nine, often suffering "terrible tears," including fistulas, when they give birth at 10 or 12 years.

Husbands often immediately divorce women with fistulas, many of whom, in turn, hang around hospitals — sometimes for several years — hoping to get surgical repair.

Dr Aimahmoud said female circumcision should be seen as an issue of maternal and child mortality and morbidity, not a cultural matter.

She said she had heard a man from UNESCO say it was not a health issue, but an issue of "human rights and dignity."

"Women don't die from dignity, but from infection and in childbirth."

Women in Nairobi
Backdrop for the future

A minority welcome: United Nations and government officials — mostly male — dominate the opening ceremonies. They were soon to be dramatically out-numbered by women

Forum 85 — rich and poor, the impact was mutual

Forum 85, the NGO conference, was the first conference of such magnitude —between 14,000 and 16,000 people — held in a Third World country, and the impact on Kenya and on the visitors was mutual. Holding the conference in Kenya allowed more Third World women to attend, particularly African women.

The Kenya setting also brought home to Western visitors the reality of unfamiliar problems with far more impact than would have occurred in a London or New York convention centre.

The African women who took a prominent and influential role were highly educated and articulate, aware of their goals and of the difficulties they face in reaching them. There were also rural women from all over Kenya, many with little formal education, or fluency in English.

"What could they possibly get out of it?" one woman asked.

Lillian Kimani, a psychologist who counsels women and men whose lives have been disrupted by rapid cultural change, said she welcomed the opportunity for the rural women to attend.

"These women, too, will face major changes in their lives before long. It is good for them to see new things and to broaden their horizons."

Developing countries are sensitive that their facilities and organization may be considered less efficient than those of cities where coping with thousands of convention visitors is the norm.

Problems there were: NGO delegates were told to vacate hotel rooms booked and paid for in advance to make room for official UN delegations. But, this was resolved by women voluntarily sharing rooms.

The Kenyan government was criticized for prettying Nairobi streets by removing prostitutes, beggars (many blind or with crippling disabilities), and fruit vendors.

One speaker told a prostitution workshop that to avoid arrest some Nairobi prostitutes dressed up like West African delegates to the conferences, or as hospital nurses "coming off duty."

A petition seeking signatures against jailing prostitutes and clearing streets called Kenya "a highly oppressive society."

But, Kenya and Nairobi were proud of hosting the conference. Taxi drivers asked what you thought of their city as they hurtled through dense traffic at manic speeds.

(Meters are unknown, so fares varied on every trip. Sometimes, a driver unfamiliar with a route would ask "What do they usually charge you?")

Nairobi shopkeepers had a field day, and the daily newspapers ran long stories and good-humored cartoons

The University of Nairobi campus green provided a central area for constant, informal, spontaneous interaction that was probably as valuable as organized workshops and likely would not have happened in the same way in a formal, indoor setting.

Opportunity to meet was not confined to women from different continents: one sign exhorted: "Network with other Asian Women." Another announced a meeting to "exchange ideas" among women's groups from more than 20 African countries.

On the whole, the conferences all went well, and the insights gained by having large numbers of women from The Third World, many of whom would have been unable to travel to Europe or North America, more than compensated for inconveniences.

Street dramas help teach rural Indians

Actors carry a message of drunken violence against women into the streets in the slums of Ahmedabad, 500 kilometres north of Bombay.

Ila Pathak, secretary of Ahmedabad Women's Action Group (AWAG), told **The Journal** that specially-written street dramas have proved an effective tool in community education.


Poster detail

AWAG began with a group of educated, middle-class women, many of them teachers and university professors, who became incensed at the portrayal of women in Indian textbooks and media.

All, she said, denigrated the dignity of women, or portrayed them as sex objects. Even *suttee*, the custom of burning a widow on her husband's pyre, was glorified in textbooks. Although forbidden today, *suttee* still occurs in India, perhaps once a year, Ms Pathak said.

The volunteers began working on a long-term basis with some 3,000 or more people in three slums in the city, where both women and men, even pregnant women, haul coal. The work is so heavy they cannot work for more than three days without rest, and many suffer from lung and stomach ailments.

Ms Pathak said it took many months of patient work, beginning with mothers and young children, to gain the trust of the community, but now AWAG runs a number of well-attended programs, including literacy classes, pre- and post-natal child care, immunization, and nutrition clinics.

Alcoholism is a major problem in such depressed areas and leads to various forms of violence. Bride-burning, which was also the subject of a slide show by another Indian group at Forum 85, is increasing. Usually, this results from what the husband or his family consider insufficient dowry, and often the death is covered up as an accident or suicide.

Genuine suicides are all too common. Ms Pathak said Indian women, traditionally trained to submission, "are easily pushed to death."

AWAG strives to raise their self-awareness, showing them other solutions to their problems.

Photographs she showed of one street drama depicted a drunken husband beating his wife and trying to drag her to his creditor's house in payment for his debts. But, friends and neighbors ran up and surrounded her, protecting her.

Another showed the wife running to her neighbors who called in a social worker. Surrounding the actors were a large group of spectators, adults and children. Ms Pathak said the street dramas are well received, and seem to have made an impact in the community and among the women.

NEXT MONTH: More on the UN Decade for Women Conference and Forum 85

Photos by **Joan Hollobon**, *except those on the bottom of N-1, top of N-2, and top of N-4.*

SPECIAL REPORT

The Illicit Drug Situation in Canada and the United States

Cover detail from RCMP/DEA report

While both Canada and the United States share similar problems with illegal drugs, many aspects of Canadian trafficking and use differ from patterns in the US.

So concludes a special joint report between the Strategic Intelligence Section, Office of Intelligence, US Drug Enforcement Administration, and the Strategic Analysis and Publications Section, Drug Enforcement Branch, Royal Canadian Mounted Police.

The report, The Illicit Situation in the United States and Canada, *is based on the most current statistical information available for both countries. Comparisons are made, based on 1983 Canadian and US drug intelligence estimates (*The **Journal,** *January, 1985) and the trend information is current as of the end of December, 1984.*

The **Journal** *presents the report below, summarized by contributing editor* **Karin Maltby**.

Cannabis

CANADA: Cannabis and its derivatives remain the principal drugs used throughout Canada and continued to be abundant in all regions during 1984. Although there was an overall decrease in the number of people charged with cannabis-related offences in 1983, the number of people charged with importation and cultivation increased significantly.

Recent drug surveys have indicated a decrease in the overall use of cannabis, possibly the beginning of a downward trend in marijuana consumption.

As in the US, most of the cannabis smuggled into Canada is by sea.

Wholesale prices for Colombian marijuana are higher in Canada than in the US, but retail prices for Jamaican cannabis are lower in Canada. There is a great variation in price ranges for *sinsemilla* in both countries.

US: Marijuana use patterns changed slightly in 1984. Cannabis-related hospital emergencies are projected to decline, although the number of emergencies varies widely from city to city.

Changes in use patterns reflect the rising use of high-potency *sinsemilla* and the consumption of marijuana in combination with other drugs — especially alcohol, cocaine, and phencyclidine (PCP).

In spite of a continued demand for domestic *sinsemilla* among older, experienced users, the high price has tended to discourage greater use. Domestic marijuana is now preferred over foreign varieties, but when it is in short supply, users prefer Colombian cannabis.

The US marijuana situation continues to be characterized by diversity, with both domestic and other foreign varieties competing with the Colombian product.

Non-commercial vessels are the principal smuggling conveyance for most marijuana reaching the US from foreign sources. Other cannabis products of lesser significance include hashish from the Middle East, hashish oil from Jamaica, and marijuana from Thailand in the form of Thai sticks.

Cocaine

CANADA: During 1984, cocaine continued to attract new users from all socio-economic classes and younger age groups.

The supply of cocaine throughout Canada ranges from limited availability in the smaller communities and remote areas to plentiful in the major metropolitan centres.

Increasingly dangerous forms of use have been reported in Canada, similar to trends in the US. For example, reports of cocaine injection, rather than the usual snorting, were noted in Ontario. And, in Winnipeg, there have been reports of PCP being mixed with cocaine. The increasing availability of cocaine may lead some users to experiment with more potent and lethal combinations and methods of administration.

Colombia remains Canada's principal cocaine supplier. Bolivia's share of the total supply dropped and Brazil's increased, indicating Brazil has assumed a wider role in international cocaine traffic.

As in the US, there have been instances of unprocessed cocaine being smuggled into Canada. There has been a significant shift in transportation modes for cocaine reaching the country. The use of air transportation has declined and land transportation has increased, reflecting a greater use of the US by traffickers as both a point-of-purchase, and as a trans-shipment area.

Canadian cocaine prices tend to be higher than those of the US.

US: There was a continued increase in cocaine-related hospital emergencies and deaths in 1984. Increases of 49% and 37% respectively, are projected over 1983 levels. The increase in both hospital emergencies and deaths is attributed primarily to increasingly dangerous forms of use — freebasing (smoking), injection, and combining cocaine with heroin in "speedballs." Cocaine in combination with alcohol, heroin, and PCP continued to increase in frequency of use in 1984.

Nationally, wholesale purity levels generally average about 90%, and retail purity levels about 35%. Increasingly, cocaine base is being smuggled into the US, as evidenced by the increased number of cocaine laboratories seized — especially in south Florida.

While Colombian consortiums dominate the illict traffic at the wholesale level, the ethnic composition of lower-level wholesale and retail distribution remains mixed. A majority of the cocaine reaching the US is smuggled in by air.

Heroin

CANADA: Heroin availability continued to fluctuate throughout Canada during 1984. Generally, heroin is more plentiful in major population centres in Quebec, Ontario, and British Columbia, than in more sparsely populated regions.

The single, most significant change in 1983 was the resurgence of southeast Asian heroin in the country. It accounted for 68% of the supply in 1983, compared to only 21% in 1982. This situation is expected to continue in the next few years.

Principal indicators of arrests and seizures suggest an increase in use and availability of heroin in Canada.

The drug enters the country primarily by commercial air couriers, although there has been increased smuggling via land since 1983. The postal system is also being used extensively to import small quantities of both southwest and southeast Asian heroin. International airports in Toronto, Vancouver, and Montreal continue to be the most popular entry points for heroin imported into Canada. In 1983, these cities, as well as Ottawa, were used as trans-shipment points for heroin en route to the US.

Wholesale heroin prices in Canada are comparable to US prices.

US: Heroin use patterns in 1984 remained relatively unchanged from 1983. Heroin-related hospital emergencies and deaths are projected to increase slightly, and heroin in combination with alcohol and cocaine likewise continues to show increases in frequency of use. The average retail purity is 4.7%.

Southwest Asia continues to be the primary source of heroin for the US, and its share of the total national supply (49%) remained unchanged at about 1983 levels.

In 1984, Mexican heroin's share of the total supply increased to 37%, and southeast Asian heroin's share decreased to 14%. Two clandestine heroin laboratories were seized in 1983.

Most of the heroin reaching the US is smuggled by commercial aircraft, although most Mexican heroin enters the country via land transportation.

Other drugs

CANADA: Clandestine laboratories operating here are believed to be responsible for most of the methamphetamine, PCP, and the amphetamine analogue MDA available in Canada. Diazepam (Valium) is being used to produce counterfeit methaqualone (Quaalude) tablets intended primarily for the illict US market. Genuine methaqualone continues to be produced in clandestine Canadian laboratories, albeit on a smaller scale.

LSD, produced primarily in US clandestine laboratories, also continued as a major drug of abuse in Canada in 1984.

The financing, manufacture, and distribution of illicitly produced chemical drugs in Canada tend to be dominated by outlaw motorcycle gangs operating throughout the country with strong links to their US counterparts.

There has been a resurgence of methamphetamine use in Canada since 1983. Psilocybin is available in many regions, particularly in western Canada.

The appeal of look-alike preparations appeared to be declining in 1984; however, cocaine look-alikes were encountered in many areas of the country. The diversion of legitimately produced drugs remains a major problem in Canada.

US: Methamphetamine use and trafficking stabilized after a period of decline in 1983. Domestic, clandestine manufacture remains the primary source of illicit supply.

The use of oral dosage forms of amphetamine continues to decline, but most amphetamine in this form comes from Mexican sources.

There has also been an increase in the manufacturing of MDA. As for depressants, methaqualone use continues to decline as a result of shortages of bulk methaqualone powder, a consequence of more stringent international controls.

Most purported Quaalude tablets available in the US are counterfeit, generally containing an alternative depressant or sedative substance such as diazepam or phenobarbitol. Many methaqualone users have shifted to diazepam which is diverted from licit sources. Reportedly, there is a significant amount of smuggling from Canada, Mexico, and Colombia.

In certain areas, PCP use and availability continued to increase in 1984, as did the growth of PCP use in combination with other drugs — frequently heroin. The entire illicit supply of PCP is manufactured in clandestine laboratories.

Trafficking in LSD and peyote increased in 1984. But, LSD hospital emergencies are projected to decline from 1983 levels.

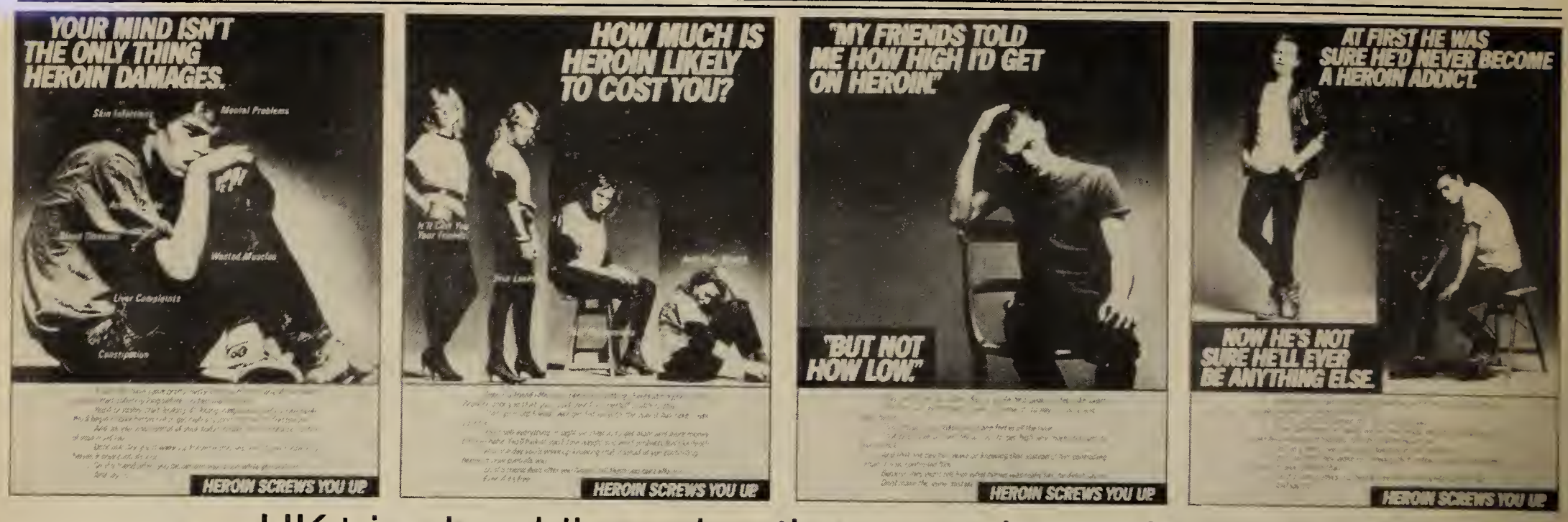
There has also been a major shift in preference from pentazocine (Talwin) to codeine preparations and hydromorphone (Dilaudid).

1984 Retail Price Ranges for Illicit Drugs

Canadian prices in Cdn dollars, US prices in US dollars

	Canada	United States
Cannabis		
• sinsemilla (ounce)	$ 81. — $ 312.	$100. — $175.
• domestic (ounce)	34. — 129.	45. — 65.
Cocaine (gram)	156. — 210. (50% pure)	100. — 120. (35% pure)
Heroin	625. — 1046. (1 gram, pure)	45. — 65. (1.5 gram, 4.7% pure)
Methamphetamine (gram)	81. — 156.	60. — 100.
Amphetamine (dosage unit)	3.12 — 5.23	2.50 — 4.
Methaqualone (genuine, dosage unit)	3.12 — 5.23	4. — 15.
LSD (dosage unit)	2.10 — 12.56	2. — 5.
Hydromorphone (4 mg Dilaudid)	54.	30. — 50.
Pentazocine (Talwin)	10.46 — 16.	11.
Oxycodone (10 mg dosage unit)	3.12 — 5.23	2. — 3.50

INTERNATIONAL



UK tries hard-line advertisements in youth press

These advertisements appearing in the "youth" press are part of the British government's national publicity campaign to reduce heroin addiction. The effects of the campaign are being closely monitored over a 12-month period. Some specialists have given the program only muted support on the grounds that similar efforts elsewhere have proven ineffective. But, a spokesman for the Department of Health and Social Security told **The Journal** *pilot studies had suggested the format. Heroin use among the young is way up, the government says.*

Abuse 'too often not regarded as immoral, anti-social'

Soviets crack down on alcohol production, use

By Charles-Gene McDaniel

MOSCOW — The Soviet Union is adopting stern measures to curb its notoriously high rate of alcoholism by reducing production of alcoholic beverages and imposing stiff penalties against alcohol abusers.

Starting in 1986, the output of hard liquor is to be reduced in favor of soft drinks: "by 1988, production of alcoholic beverages based on fruit and berry juices is to be stopped completely."

These steps were outlined in documents published this spring in Moscow and reported subsequently in *News from Ukraine,* an English-language publication produced in Kiev.

While no good data are available on the rate of Soviet alcoholism, authorities have long acknowledged it is a serious and costly problem.

After the new measures were announced, the Soviet newspaper, *Izvestia,* cited a government study indicating that economic losses from alcoholism far outweigh revenues from liquor taxes. Tax revenues are estimated by Western analysts to equal Cdn $66 billion (1983), about 11% of the national budget.

Soviet authorities also blame liquor for 75% of all murders and rapes, 80% of robberies, 90% of hooliganism, and most divorces, although no numbers are given.

Visitors to Moscow note that the ubiquitous bottles of vodka are capped with foil, rather than corks or replaceable caps, a practice that seems to encourage consumption of the entire bottle rather than a few drinks.

The Communist Party central committee adopted a resolution on alcohol abuse that, the Kiev newspaper reported, "notes the great social harm of alcoholism, points out that alcohol abuse is too often not regarded as immoral and anti-social behavior and that the force of the law and public opinion are not brought fully to bear on drunkards."

The central committee worked out measures along with the presidium of the USSR Supreme Soviet and the USSR council of ministers "aimed precisely at removing these shortcomings.

"A national comprehensive program will be worked out to prevent and combat alcoholism, covering social, economic, educational, legal, and other aspects of the problem," the newspaper reported.

The measures also envision stiff penalties for people abusing alcohol, including heavy fines for drinking in the streets, at stadiums, and in parks, or appearing drunk in public places. Larger fines will be levied against repeat offenders.

Drunk drivers will be fined even more heavily, with 100 roubles (Cdn $63) the penalty for a first offence, or loss of driving privileges for one to three years. Stronger, unspecified measures will be taken against repeat offenders.

I was told on a recent visit to the Soviet Union that people found drunk in the street are taken to a hostel for overnight lodging and are fined the equivalent of nearly a week's wages. The police photograph them in a drunken state; the pictures are posted in their workplace to embarrass them, a common method of social control in the Soviet Union.

The proposed measures include particularly tough penalties against people, including parents, who offer alcoholic beverages to minors. The legal age for drinking has been raised from 18 to 21 years, and the sale of alcoholic beverages to those under-age is prohibited. Anyone responsible for getting a minor intoxicated will be imprisoned or subjected to "corrective labor."

The government also plans a crackdown on home brewing, moving quickly on this score. Official newspapers reported hundreds of moonshine stills were destroyed after some of the measures went into effect June 1. One still was run by an old woman, producing *samogon,* the Russian version of moonshine, for an entire village.

There was no mention in the report of removing potatoes, the basis of vodka, from the list of products used in alcohol production.

Vodka is expensive by North American standards, costing $5.40 to $7.70 per half litre while the average Soviet factory worker earns about $209 a month.

The anti-alcohol campaign will include scientific literature, television programs, and films on alcoholism, as well creation of a nation-wide volunteer temperance society with its own publication.

The Kiev newspaper reports more emphasis will be placed on healthy rest and recreation opportunities, especially for the young.

Although the report did not link the new program to reduce alcohol abuse to the policies of Mikhail S. Gorbachev, the new premier, the measures come as he is presenting hard-hitting new programs to cope with the problems of his sprawling country.

Moscow: police photograph drunken workers and post the pictures

Women's hostel for Israel

TEL AVIV — Israel's first hostel for women alcoholics has opened in Ramat Gan, a large (100,000 people) suburb of Tel Aviv.

To begin with, the women's hostel will accommodate only three women at a time, for a 10-week residential course. The hostel shares space with a men's hostel, opened in December, 1982 to supplement 11 ambulatory treatment centres scattered throughout Israel.

Full financial support comes from the Ministry of Labor and Social Welfare. Spokeswoman Pnina Eldar says Israel has 15,000 alcoholics, 10% of them women. Of the 15,000, only 3,500 sought ministry help during the past decade, including a few severe cases who were hospitalized in psychiatric wards.

The rate of cure there was "nil," Ms Eldar says, so the hostel was set up to accommodate 25 men. Three of these positions are now being given to women.

Several hundred men have used the hostel. Of 166 studied, half left the course. Of those who finished, 55% remained abstinent for the year after discharge and 43% abstained for two years.

"These are high cure rates by any standards," Ms Eldar says. She notes the average age of alcoholics is dropping in Israel, to 41 years now from 55 years two decades ago. The number of women alcoholics is steadily increasing, particularly for women from United States and European backgrounds.

NEWS

AA helped create research climate, says Niven

MONTREAL — Alcoholics Anonymous (AA) has made important contributions to the prevention of alcohol-related health problems as well as alcoholism, says Robert Niven, MD, director of the United States National Institute on Alcohol Abuse and Alcoholism (NIAAA).

"Through developing in its members a sense of optimism, AA has brought about a lessening of the stigma formerly associated with being a researcher on alcohol. In this way, AA has helped create a climate which facilitated the development of research into alcohol-related problems," Dr Niven told the AA 50th anniversary convention here (**The Journ**al, August).

The NIAAA has supported and encouraged the integration of AA into treatment programs, he said.

Leonard Blumenthal, assistant executive director of administration and services, the Alberta Alcoholism and Drug Abuse Commission (AADAC), said he worked in the alcoholism field for "some" years before a "flash of insight" made him "realize I should simply accept that AA does work.

"Going on from that acceptance, my job was to assist those recovering from alcoholism in every way possible."

Services available to alcoholics have improved in Alberta during the past 10 years, he said, with 70 treatment and rehabilitation locations now operating.

"AA is considered the on-going therapy for all individuals who are going through treatment programs," Mr Blumenthal said.

The AADAC has AA members at every level, from the board of directors who set policy, to people working in detox centres who come in daily contact with patients, he added.

Laura Heuter Bass, executive director of the Albuquerque, New Mexico area of the US National Council on Alcoholism (NCA), said more alcoholism agency representatives are needed on drunk-driving commissions.

"We see representatives of Mothers Against Drunk Driving and the liquor industry, but few representatives of alcoholism agencies. We need such people on the commissions to support the need for screening, early intervention, and rehabilitation of people suffering from alcoholism."

She said 60% to 70% of first-time offenders screened by the NCA exhibit severe alcoholism problems.

"An alcoholism agency is not the road to recovery. It's just the bridge leading to that road," Ms Bass said. "The bulk of our alcoholic population is still hidden and sealed off by ignorance and stigma."

Women, blacks, and homosexuals charge AA with bias

MONTREAL — Women, blacks, and homosexual alcoholics are complaining that the fellowship of Alcoholics Anonymous (AA) is "too lily white."

At a seminar on minorities at the 50th anniversary convention of AA here, a black sociologist charged that AA "should stop living in a color-blind world."

A black homosexual agreed with him. "We have a meeting for homosexuals and for women here, but we have no meeting for blacks. We better damn well have a black meeting at the next convention."

On motion of the sociologist, it was unanimously agreed to set up a permanent commission to deal with blacks and other minorities belonging to AA.

Ironically, an AA member on another panel cast prejudice aside among AA ranks today, and linked it only to an historical perspective.

John L. from Georgia: "It seems ludicrous today, but in the beginning, a person had to have a drinking history of at least 20 years. So, young people were out. Blacks were not permitted to attend (in Georgia), although eventually they were allowed to attend open meetings as observers."

He continued: "Attendance by women was frowned upon. They (AA) also drew the line at accepting dope fiends, criminals, fallen women, homosexuals, and so on.

"Out of this turmoil, came AA's third tradition: the only requirement for membership is the desire to stop drinking."

However, a black delegate said he'd encountered several Ku Klux Klan members at some of his first AA meetings, and commented: "In terms of prejudice, AA is not any different from the community-at-large."

And, for a black, female Al-Anon member at the convention, women are even "lower down" than blacks in the AA echelon: "I want to recognize my blackness, and my sex, and their cultural importance," she said.

Family practice plan helps drinkers

COLUMBIA, SC — Enthusiastic participation by physicians in a program originated by Jerry McCord, director of the South Carolina Alcohol and Drug Abuse Commission, is leading to early help for substance abusers here.

The three-year, $150,000 project, funded by the state assembly, was initiated to solve the problem of making sure alcoholics follow-up when physicians refer them to other professionals for counselling. Usually, there are no guarantees patients will go on to get the help they need. In fact, alcoholics are more likely to continue denying the problem.

"Dealing with alcoholics has traditionally left physicians without the feeling they could make a difference," Mr McCord states.

"Many times, their experience with alcoholism came in emergency rooms, where they encountered obnoxious drunks who have injured themselves or others. Doctors felt hostile, apathetic. The key is that they never saw anyone recover."

Under the family practice program, addiction counsellors across the state work out of spare offices of family physicians, intervening with patients in the early stages of alcohol abuse.

Doctors who suspect patients of chronic drinking confront them and suggest counselling. With help as near as the next room, it is easier for substance abusers to take the first step, especially in a setting where the stigma of repeated visits is less than at the commission. Patients are also more likely to keep appointments at a doctor's office than at a mental health agency, where no-shows are common.

"In our field," Mr McCord said, "we do see recovery. And through this project, doctors can take credit for that recovery."

Addictionology a specialty?

MONTREAL — Addictionology is a science that will, one day, become a specialized field of medical practice, predicts a United States pathologist.

Jasper Chen See, MD, from St Joseph's Hospital, Reading, Pennsylvania, told **The Journal** during Alcoholics Anonymous golden jubilee convention here: "The more we learn about alcoholism, the more we realize that special knowledge is required. A knowledge of addictionology is not something you tumble into.You have to study(it) and eventually it becomes a specialty."

Dr Chen See recommended a one- or two-year residency be required for a physician to specialize in addictionology.

He foresees the program will attract physicians.

Kenneth Williams, MD, a non-AA trustee from the US, agreed with Dr Chen See that the lack of training in alcoholism in US medical schools is a "national disgrace."

Dr Williams said alcoholism is the second leading cause of death in that country, yet medical students spend more time studying obscure diseases than addiction.

Parents best drug defence says Chalmers

ST JOHN — Everett Chalmers, MD, challenged parents at the annual meeting of the English section of the New Brunswick Federation of Home and School Associations, to handle youth drug problems.

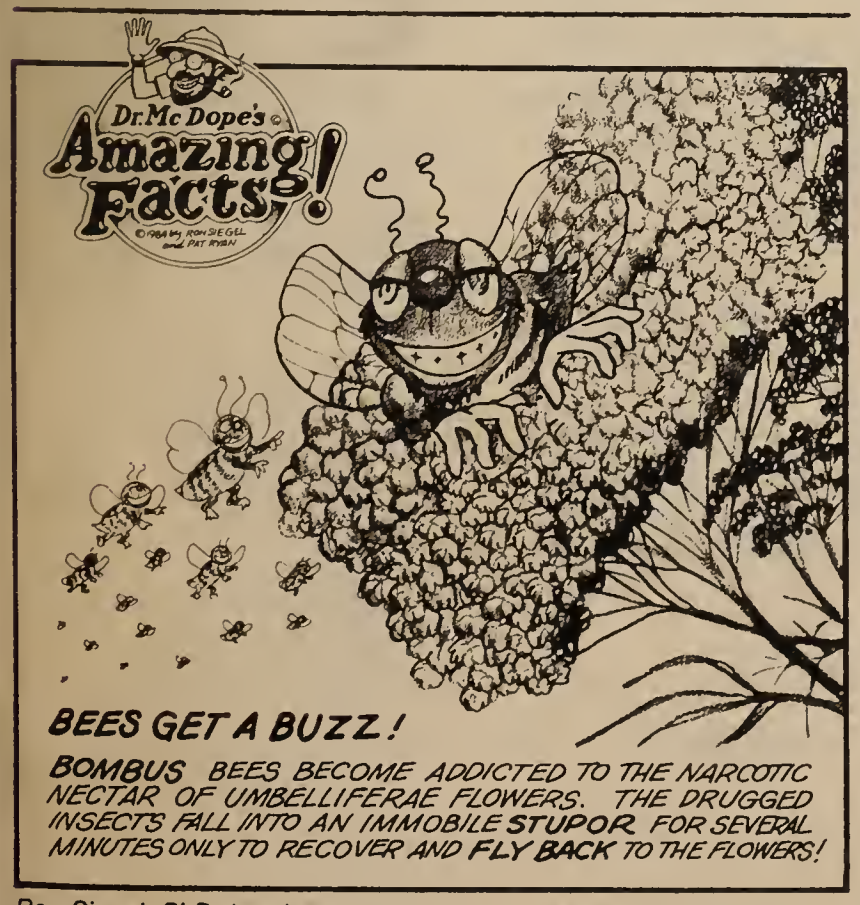
"If you, as a parent, are unable to turn your child from drugs, who else will?" he asked.

Calling for cooperation between parents and young people in preventing drug problems, the chairman of New Brunswick's Alcohol and Drug Dependency Commission said: "Many parents have become so frightened about illegal drugs that they turn a blind eye to the use of alcohol by their children."

He said parents must recognize that alcohol, marijuana, and other drugs are easily available, and that many consider their use acceptable because such substances are incorrectly thought to be relatively harmless.

Parents must communicate drug facts to their children, he said, including "why you are afraid of drug use. Be honest . . . let your child know that you want to help him and that you are hurt, disappointed, and worried, and more important, that you still love him or her."

Dr Chalmers said parents must become more informed about drugs, be more active in neighborhood and community groups and agencies, and encourage proper drug education.



Ron Siegel, PhD, has been using cartoon character Dr McDope as a drug education device in the alternative press for 10 years. "Amazing Facts" presents unusual, factual information in an amusing way, explains Dr Siegel of the Neuropsychiatric Institute, University of California, Los Angeles. Artist Pat Ryan assists with design and art for the series.

Lung awards to newspapers

OTTAWA — Two newspapers and one magazine have received Canadian Lung Association recognition for refusing to accept cigarette advertisements.

The *Kingston Whig Standard* (**The Journal**, February) and the *Brockville Recorder and Times* newspapers, and *Canadian Geographic* magazine have been given citizenship awards.

DEPARTMENTS

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

My Father's Son: The Legacy of Alcoholism

Number: 659.
Subject heading: Alcohol and the family.
Details: 33 min, color.
Synopsis: A man working in his basement finds a bag of what appears to be marijuana. The film recalls in flashback, his childhood with an alcoholic father, the absence of friends, fear for his mother and younger brother, family arguments, and determination never to be like his father. In one sequence, after a violent argument with his drunken father, he runs out and goes to a friend's house. There, he gets drunk and spray paints on a brick wall "I Am My Father's Son."

He is now afraid that because his father was an alcoholic and he himself has had problems with alcohol, that his son will have problems with marijuana. He will not tolerate his son using marijuana because he feels each member of the family is at great risk of becoming addicted. The son leaves the house saying that he can handle it.
General evaluation: Good (4.3). This contemporary, well-produced film had great emotional impact. However, the A/V group would not endorse the concept that if alcoholism runs in a family, family members will also have problems with cannabis. General broadcast was recommended.
Recommended use: This film could benefit audiences 12 years of age and older.

Alcoholism: Life Under the Influence

Number: 655.
Subject heading: Alcohol/alcoholism-overview.
Details: 57 min, color.
Synopsis: Alcoholism can happen to any drinker. One in 10 drinkers in the United States develops problems. Scientific studies have been conducted over many years to try and understand what the American Medical Association recognized in 1966 as a disease. A variety of investigations including biological, psychological, treatment, and educational studies have been conducted. Many questions remain unanswered and research continues.
General evaluation: Very good (5.4). This film is an excellent teaching aid, dealing with the major social and individual aspects of alcohol problems. General broadcast was recommended.
Recommended use: With a resource person, this film would benefit all ages.

Students Take Action

Number: 662.
Subject heading: Impaired driving.
Details: 20 min, color.
Synopsis: Some high school students, concerned about their peers' drinking and driving habits, set up a program, "Safe Rides." After a training program, they operate a service, supervised by adults, which provides transportation for young people who have been drinking and should not drive.
General Evaluation: Fair to good (3.9). This film showed a good idea communities could incorporate into their drunk-driving campaigns. General broadcast was recommended.
Recommended use: With a resource person, this film could be used with general audiences and community consultants.

One Man's Fight for Life

Number: 663.
Subject heading: Smoking.
Details: 56 min, color, video only.
Synopsis: Saif Ullah had been smoking cigarettes for 18 years, when he was diagnosed as having lung cancer. This film follows Saif for almost a year, as he undergoes a variety of treatments. It shows how he faces his problems with hope and determination, and reveals the effect his disease has on his family, the ways in which they cope with his increasing deterioration. Saif expresses anger at his smoking and at the way in which smoking is glamorized in society. He experiences great frustration at the lack of cure for his disease. The treatments he receives are not successful, and after a great deal of physical and mental pain, Saif dies.
General evaluation: Very good (5.3). This film has great emotional impact. General broadcast was recommended.
Recommended use: With a resource person, this film could benefit audiences 15 years and older.

Pot

Number: 664.
Subject Heading: Cannabis.
Details: 30 min, color.
Synopsis: A psychiatrist is lecturing a group of teenagers on the effects of cannabis on various body systems. He tells of potential damage to the bronchial, immune, and reproductive systems. Acute and chronic effects on the brain are discussed and consequences affecting perception, motivation, thought processes, and driving skills.
General evaluation: Very poor (1.0). This film was poorly produced, and judged harmful because of its incorrect, questionable information.
Recommended use: None.

Books

Psychiatric Emergencies — Dubin, William R., Hanke, Nancy, and Nickens, Herbert W. (eds). Churchill Livingstone, New York, 1984. Includes chapters on drug abuse emergencies, and evaluation and management of alcohol-related psychiatric emergencies. 268p. Academic Press Canada, 55 Barber Greene Road, Don Mills, Ontario M3C 2A1.

Mental Handicap — Russell, Oliver. Churchill Livingstone, Edinburgh, 1985. Includes a short section on alcohol consumption in pregnancy. 220p. Academic Press Canada, 55 Barber Greene Road, Don Mills, Ontario M3C 2A1. ISBN 0-443-02804-4.

Clinical Biochemistry of Alcoholism — Rosalki, Sidney B. (ed). Churchill Livingstone, Edinburgh, 1984. Alcoholic in the community: hospitalized alcoholic; metabolic disturbances; organ complications. 305p. Academic Press, 55 Barber Greene Road, Don Mills, Ontario M3A 2A1. $83.70. ISBN 0-443-02582-7.

Back to Safety Basics — Canadian Safety Council, Ottawa, 1984. An integrated approach to traffic safety and substance abuse education: three resource guides for teachers of kindergarten-grade 6, grades 7-11 core subject area, and grades 7-11 general subject area. Canada Safety Council, 1765 St Laurent Blvd, Ottawa, Ontario K1G 3V4. $15.95 each, $43.50 set.

This publication is indexed in

BIHEP
BIBLIOGRAPHIC INDEX OF HEALTH EDUCATION PERIODICALS

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates.
a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
¼ Page (280 lines) $250
c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation 27,318 (Canada, 21,412, USA, 1,907, Foreign, 386, Bulk, 3,613) Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents $16 per year
US & Foreign Residents $24 per year

Bulk Subscription Rates
Purchase of 5 or more subscriptions mailed to the same address — 20% discount
Ontario residents billed as other Canadians

The Journal, 33 Russell St Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Surgeons of Canada — 54th annual meeting — Sept 9-12, Vancouver, British Columbia. Information: Robert A. Davis, coordinator, Royal College of Physicians and Surgeons of Canada, 74 Stanley Ave, Ottawa, Ontario K1M 1P4.

Fundamental Concepts Course — Sept 16-20, Jan 13-17, 1986, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

2nd Annual Corpus Workers' Compensation Conference — Sept 18-19, Toronto, Ontario. Information: Corpus Information Services, 1450 Don Mills Rd, Don Mills, ON M3B 2X7.

Ontario Public Health Association 36th Annual Educational and Scientific Meeting — Sept 22-25, Toronto, Ontario. Information: Ontario Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, ON K1Z 8N8.

Pharmacology and Drug Abuse Course — Sept 30-Oct 3, Feb 3-6, 1986, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

What an Employer Needs to Know to Make an Effective Intervention — Oct 2-4, Toronto, Ontario. Information: Yvonne Johns, intervention services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Canadian Psychiatric Association 35th Annual Meeting — Oct 2-4, Quebec City, Quebec. Information: Canadian Psychiatric Association, Ste 103, 225 Lisgar, Ottawa, Ontario K2P 0C6.

Introductory Addictions Management Course — Oct 7-9, March 17-19, 1986, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto ON M4W 2Y1.

Productivity 85 (EAP) — Oct 23-24, Saskatoon, Saskatchewan. Information: Personnel Performance Consultants, Box 7811, Saskatoon, SK S7K 4R5.

Input 85 — The 6th Biennial Canadian Conference on Employee Assistance Programs in the Workplace — Oct 27-30, Ottawa, Ontario. Information: Input 85 Headquarters, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Northern Youth in Crisis: A Challenge For Justice — Nov 3-8, Val d'Or, Quebec. Information: Northern Conference Office, c/o Continuing Studies, Simon Fraser University, Burnaby, British Columbia V5A 1S6.

Drug Education Coordinating Council Seminar on Contemporary Drug Issues — Nov 8, Malton, Ontario. Information: H.J. Schankula, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

Skill Training for Employee Assistance Personnel — Nov 17-21, Oakville, Ontario. Information: James Simon, Peel Centre, Addiction Research Foundation, 39 Dundas St E, Ste 203, Mississauga, ON L5A 1V9.

The Emotionally Disturbed Adolescent in the 80s — Nov 22, Toronto, Ontario. Information: Continuing Medical Education, Room 114 FitzGerald Bldg, 150 College St, Toronto, ON M5S 1A8.

23rd Annual Scientific and Business Meeting — Nov 27-30, Toronto, Ontario. Information: Ontario Chapter College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

United States

Family Restoration Workshop — Sept 8-12, Reading, Pennsylvania, Nov 17-21, Philadelphia, PA. Information: Caron Institute, PO Box 277, Wernersville, PA 19565.

Gestalt Therapy and AODA; Intensive Week I, Sept 16-20, Intensive Week II, Oct 7-11, Intensive Week III, Nov 4-8, Milwaukee, Wisconsin. Information: Jennifer Gordon, Training Institute, 4143 S 13th St, Milwaukee, WI 53221.

Adolescent and Family Treatment: An Investment for the Future — Sept 18-20, San Diego, California. Information: Nomi Feldman, conference coordinator, 370 Tansy, San Diego, CA 92121.

1st National Association of Lesbian and Gay Alcoholism Professionals Conference — Sept 26-29, Chicago, Illinois. Information: NALGAP, 1208 East State Blvd, Fort Wayne, Indiana 46805.

International Youth Services Conference — Oct 6-9, Chicago, Illinois. Information: Bill Treanor, executive director, American Youth Work Center, 1346 Connecticut Avenue NW, Ste 925, Washington, DC 20036.

37th Annual Convention and Scientific Assembly of the American Academy of Family Physicians (AAFP) — Oct 10-13, Anaheim, California. Information: The American Academy of Family Physicians, 1740 West 92nd St, Kansas City, Missouri 64114.

Reality Therapy and AODA: Introductory Workshop — Oct 11, Dec 13, Milwaukee, Wisconsin. Information: Jennifer Gordon, Training Institute, 4143 S 13th St, Milwaukee, WI 53221.

Alcoholic Beverage Control: Prescription for Public Health — Oct 13-15, San Diego, California. Information: ABC Conference, UCSD Extension, X-001, La Jolla, CA 92093.

Children at Risk: Alcohol and the Elementary Student — Oct 17-19, Milwaukee, Wisconsin. Information: Jennifer Gordon, Training Institute, 4143 S 13th St, Milwaukee, WI 53221.

Assessing Adolescent Drug Abuse in the School: Concepts, Tools and Skills — Oct 21-25, Milwaukee, Wisconsin. Information: Jennifer Gordon, Training Institute, 4143 S 13th St, Milwaukee, WI 53221.

Making A Safe Place: Leading AODA Support Groups in Schools — Oct 21-25, Nov 11-15, Dec 9-13, 1985, Milwaukee, Wisconsin. Information: Jennifer Gordon, Training Institute, 4143 S 13th St, Milwaukee, WI 53221.

When Chemicals Come to School: Core Group Training for Student Assistance Programs — Nov 4-8, Milwaukee, Wisconsin. Information: Jennifer Gordon, Training Institute, 4143 S 13th St, Milwaukee WI 53221.

National Federation of Parents for Drug-Free Youth, 4th annual conference — Nov 6-9, Washington, DC. Information: Mary Jo Green, NFP, 1820 Franwall Ave, Ste 16, Silver Spring, Maryland 20902.

Association of Labor-Management Administrators and Consultants on Alcoholism, 14th Annual Conference — Nov 10-14, Boston, Massachusetts. Information: Judith Evans, associate director, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

Association for Medical Education and Research in Substance Abuse, 9th Annual Conference — Nov 14-15, Washington, DC. Information: Dr G. Lewis, AMERSA president, Center for Alcohol Studies, Brown University, Box G, Providence, Rhode Island 02912.

10th Annual Southeastern Conference of Alcohol and Drug Abuse (SECAD 10) — Dec 4-8, Atlanta, Georgia. Information: Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, GA 30342.

Abroad

12th World Conference on Health Education — Sept 1-6, Dublin, Ireland. Information: Mary D'Ardis, conference coordinator, 12th World Conference on Health Education, 34 Upper Mount St, Dublin 2, Ireland.

European Congress on Prevention of Alcoholism and Other Drug Dependencies — Sept 30-Oct 4, Opatija, Yugoslavia. Information: International Commission for the Prevention of Alcoholism and Drug Dependencies, 6330 Laurel St, NW, Washington, DC 20012.

International Road Research Documentation (IRRD) System of the Organization for Economic Co-operation and Development (OECD) Plenary Meeting — Oct 8-10, Bergisch Gladbach, Germany. Information: OECD, Road Transport Research Programme, 2, rue Andre-Pascal, 75775 Paris Cedex 16, France.

International Congress on Local Authorities and Drug Policy — Oct 23-24, The Hague, The Netherlands. Information: Municipality of The Hague, Dr N. G. Geerts, MWV, PO Box 80.000, 2508 GA The Hague, The Netherlands.

Andalusian villagers untouched by alcohol horror stories

Drinking, drinking, and drinking in Gualchos

Spain is a hard-drinking country. There, more than 10,000 deaths a year are directly attributed to alcoholism — and thousands more to drinking drivers. A leading newspaper recently warned that alcohol consumption still increases "despite the daily horrors of its abuse on the roads."

A concerned government is now blanketing the country with huge billboards showing a glass of wine, plus an auto, equalling an ambulance. Doctors are making public statements that alcohol is the most serious drug of all.

Yet, while most Spaniards deride such drugs as cocaine and heroin as death-inducing, few consider alcohol a problem.

Spain's nearest neighbors have the highest rates of alcohol consumption in Europe: France, with an annual average of 16.5 litres of pure alcohol consumed per person; and Portugal (where cirrhosis of the liver is the second most frequent cause of death for men between 25 and 44 years) with 14.1 litres per person.

Such facts matter little in Gualchos. In a village with only eight cars, the horror stories of traffic deaths seem like foreign news. And, no one, except the sea captain who lives atop a hill, drives at night.

Paul King

*As bartender Miguel Rodriquez says, "Everybody walks home — no matter how long he's been here." **Paul King** reports on Gualchos, one small Spanish village in the Andalusians.*

GUALCHOS, SPAIN — Gualchos sits on the side of a Spanish mountain.

Except for its tiled, burnt-orange roofs, the village is entirely white; each casa looks chiselled from chalk. The houses are joined in a jumble of streets that spill and twist on the slope.

Two miles south, on the edge of a valley, the Mediterranean sweeps toward Morocco. Sixty miles east, the peaks of the Sierra Nevada stay white until July.

No one knows how long Gualchos has been here, except that the plaza fountain still spouts from a Moorish well. Just below the village stands a knoll still slitted with Civil War trenches. And, the old men say when the trenches crawled with Republican troops nearly 50 years ago, more than 2,500 people lived here.

Cheap and traditional

Today, there are 500. Most are farmers: thin, tanned men who ride their mules down snaking trails to their almond groves each dawn.

There are also about 50 foreigners, including a Scottish sea captain (who constantly crashes his car), a former Irish major (who fought in India), a Californian painter, a retired Danish headmaster, a Swedish weaver, two English television stars (who fly in and out), and an Australian (who sailed to Spain in a boat he built, then built his own house here).

The farmers and foreigners lead separate lives — except for the two-hour midday siesta, and after 7 pm. Then, most of them meet in the bars and drink.

A lot of liquor goes down in Gualchos. One reason: it's cheap; a litre of local wine costs 46 cents. Second, drinking in Spain is traditional; *vino*, to a Spaniard, is as commonplace as bread. Milk, if drunk at all, is in espresso. And, third, the bars in the village are its only recreation.

Gualchos has a church, a primary school, a butcher shop, a bakery, three grocery shops, one superb new restaurant The Posada, run by outsiders, primarily for tourists — and three bars.

The bars are, by far, the most popular. Exeept for the grocery shops, they comprise the village's sole social life. It's where you find anyone — even the priest. He goes to ehurch only on Sunday.

Each bar has its own special character — and characters.

The one at the edge of the village, where two mountain roads meet, has no sign on the white wall outside. It looks like a shed. It has only a bright green door, which is always open when the bar is. But, when business is slow or the crops are ripe, the owner pulls a corrugated metal shutter down over the entrance, takes his mule from the stall behind, and rides off to his field.

Wine by the hour

This bar is either called Manolo's, because of its owner, or The Old Men's Bar, because of its customers. It's where the village elders gather. The tiny room has two tiny tables and six wicker chairs on a polished cement floor. On the whitewashed walls hang four calendars and six plants stuck in beer cans. Cases of empties are piled in one corner. Behind a five-foot, grey-tin bar, an ancient refrigerator stands beside a sink.

But here, in the hot afternoons, the old men sit hunched across their canes, talking softly of the past, and sipping *Vino Costa* (wine of the coast) by the hour. The wine is a pale, dry claret, and the cheapest in the village: 15 cents a glass. In the evenings, farmers heading home stop off for a few in Manolo's. They drink each glass in a single gulp.

Yet, the gulps add up. Manolo sells an average of 112 litres of *Vino Costa* a week, plus another few litres of *Vino Mosto*, a costlier amber wine (19 cents a glass), made in a nearby village. He also sells another 30 litres of *Vino Costa* each week to housewives, who fill their wicker-bound demijohns from Manolo's barrels. A litre costs 46 cents. Manolo's clients drink mostly wine. He sells only about 30 small bottles of beer (26 cents each) a week, and less than a bottle of spirits.

In the centre of Gualchos sits The Middle Bar, the stopping-off spa for drinkers on the prowl. And, all the prowlers are men; for the only women in Gualchos bars (except to fill their jugs) are foreigners — or a wife storming in to drag an errant husband home. When this happens, which is rare, the room pretends not to notice.

A tiny red sign on the wall outside says *"Bebe Coca Cola,"* but nobody drinks it — straight. Inside a beaded curtain covering the door (to keep out flies, for Gualchos has 300 goats) is a 10-foot wooden bar with a modern fridge and cooler. The men line the bar, ignoring the single table, and argue politics. Here, they drink mostly beer — about 50 bottles a day, at 35 cents for a third-of-a-litre bottle. The reason: all wine is sold from brand-name bottles and is costlier (20 cents a glass) than Manolo's.

Brisk business

But, at night many young men order *Cuba Libras* (55 cents each) — which in Gualchos means *gin* and cola. No one knows why. They say that's what a *Cuba Libra* is. If you want rum, you must specify it. Also ice. No native orders ice. Thus, the major highball in Gualchos is warm gin and cola. With three ounces of gin, it's effective. Local barmen pour spirits like . . . well, wine.

The Middle Bar, however, does its briskest business Sunday mornings. It's only 30 yards from the church. The men cluster behind the back pew till the sermon starts, then dash to the bar for an hour, and return in time for the benediction.

The main action in town though, is Miguel's Plaza Bar — a large, open-windowed room in a corner of the tree-lined square. The sign outside says *"Bar-La Plaza."* It's the only illuminated sign in town. Miguel Rodriquez, 33, has run the bar for nine years, and his father for three decades before.

Miguel's a happy hustler. He collects mail for regulars and takes phone messages. He's put in a crushed-marble floor, tiled walls, an espresso machine, an electrical fly-spray, and a 30-foot, L-shaped, stainless steel bar — with colored lights on the foot rail that flash on special occasions. He's even got two toilets. (The Middle Bar has none; Manolo's is a wall outside.)

La Plaza; the only illuminated sign in town. Cuba Libras *and* tapas, *snacks of fried squid on lettuce, add up to the most popular spot in the town of Gualchos*

Even though his prices are higher, Miguel's is the most popular. And, he serves everything.

Pour 'not preach'

In an average week, he sells 210 small bottles of beer (one-fifth of a litre, for 30 cents), and 120 large (one-third of a litre, for 38 cents). He also runs through 15 bottles of Spanish-made gin, rum, or brandy — and 75 bottles of wine at 19 cents a glass).

The local *Cuba Libras*, of course, are hot sellers, though Miguel admits he finds them revolting. ("But, my job is to pour, not preach.") He's delighted when foreigners order "civilized" gin-tonics, or rum-cokes (all mixed drinks are 68 cents), and even provides ice — unasked.

He also does a brisk take-out trade, and each week unloads about 10 bottles of brandy and anisette ($2.70 each), a dozen bottles of gin and vodka ($3), 110 litre-bottles of beer (55 cents each), and 30 litres of bottled wine (46 cents each, with an empty). Everyone brings empties; the bottles cost half as much as the booze.

The three village grocery shops also stock alcohol. Each proprietor estimates he sells an average of 10 bottles of spirits, 40 litres of beer, and 60 litres of wine each week. Prices are slightly lower than Miguel's, but the shops close at sunset.

At 1 pm, the Plaza Bar fills with farmers who drink wine and discuss crops, and foreign men who drink beer and discuss each other. Most stay till after 2 pm, then leave.

But, there's always the same dozen Spaniards who stay all afternoon, seated at one of the six square tables, playing cards. The game is called *Altuerto*. I can't understand it. I only know you use bottle caps for chips, and have to shout. Incessantly. Conversation is impossible within 10 feet of the players. Four men play; the others watch; everyone hollers. The men are either retired, too rich to work, or unemployed. The wealthy own large family farms; the unemployed are waiting to pick crops (for $15 a day).

After 7 pm, the bar fills up again. The foreigners return with their wives. One canary-blonde English woman arrives alone — after a lonely day spent warming up with gin. She's sweet, if incomprehensible.

And, the long Spanish night begins. The shepherds arrive in from the slopes. The priest smiles. The card players shout. The others shout to be heard above the shouters. The young men drink *Cuba Libras*. And, the booze flows.

Yet, rarely in Gualchos, does anyone get visibly drunk — except the two or three people who as anywhere make it a vocation — despite the quantities most people appear to drink.

The main reason is the *tapas*. With every beer or glass of *vino* served, a customer always gets a small, free snack (a *tapa*), on a saucer. But, only with beer or wine. Ironically, with the costlier spirits, you get nothing.

In Gualchos, *tapas* run from fried peppers to sardines, always served with bread and skewered by a toothpick. Because of his cheaper prices, Manolo often serves simple chunks of tomatoes or cucumbers, heavily salted, or squares of lard, or tiny spiced omelettes. The Middle Bar usually serves almonds or peanuts. But, Miguel comes close to gourmet snacking: chunks of roast lamb, crunchy black sausages, and sometimes even fried squid on lettuce. Patrons often order another *vino* just for his *tapas*.

If someone gets drunk in a Gualchos bar, it's usually because he primed up beforehand. Among foreigners, it's not infrequent. As Miguel points out, "It's hard to get drunk if you're constantly eating." (And he makes an average of 200 *tapas* a day.)

Miguel laughs. The Cuba Libras flow. The card players shout. Life, in Gualchos, goes on.

Gualchos: burnt-orange tiled roofs, white casas, and people who like to drink

THE BACK PAGE

MDs know nothing about alcoholism? Rubbish, says Howell
p4

Alcohol policy in Canada — a maze of conflicting interests
p7

icaa CIPAT
AADAC

- *drug laws*
- *treatment*
- *economics*

p3

Vol. 14 No. 10 2nd Class Mail Reg No. 2776 TORONTO, October 1, 1985

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Disease will challenge alcohol, drug treatment programs

US officials sound AIDS alarm to field

By Harvey McConnell

WASHINGTON — United States officials are bracing the substance abuse field for an inexorable rise in cases of acquired immune deficiency syndrome (AIDS) among intravenous drug users.

Facts, allied with the ethical and political turmoils ahead, were spelled out by the chiefs of concerned agencies at the annual conference here of the Alcohol and Drug Problems Association of North America.

The majority of 12,000 AIDS cases reported in the US have been among male homosexuals (74%), but at least 25% are among intravenous (IV) drug users, who generally die in a much shorter time than other AIDS patients. The number of AIDS cases doubles each year, there is no vaccine in sight, and no one with clinical manifestations of the disease has recovered.

Ian Macdonald, MD, head of the US Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) said AIDS has replaced cocaine as the agency's priority and warned "we are just seeing the start of tremendous devastation."

AIDS — 'the most significant crisis' *Back Page*

Jerome Jaffe, MD, acting director of the US National Institute on Drug Abuse (NIDA), said: "We really feel it is going to have an incredible impact not fully perceived by people in the field." He believes "it is going to be the most significant crisis I can possibly imagine."

Robert Niven, MD, director of the US National Institute on Alcohol Abuse and Alcoholism, said he foresees some treatment programs will refuse to admit people who are IV drug users, homosexuals, or prostitutes, the three major groups at risk of developing AIDS. The "alcoholics vs druggies" conflicts of old will now be revived, he said.

The best available information on AIDS for addictions workers is being drawn up by agencies in ADAMHA, in the US National Institutes of Health, including the National Cancer Institute, and other agencies in the US Public Health Service, such as the Centers for Disease Control, which provide much of the data about the disease.

Macdonald

Jaffe

Officials at NIDA plan to hold lengthy workshops for single state agencies and others in the field in all 50 states, discussing how AIDS spreads and what can be done to minimize the risks.

At the moment, most (about 80%) of IV drug users with AIDS live in the New York-New Jersey area. In New York, nearly 50% of AIDS victims are IV drug users, whereas in California only 2.5% are. Several sparsely-populated states, such as Montana and the Dakotas, have not reported any AIDS cases among IV drug users.

Pressure is being applied for funds to mount a nationwide prevention campaign in cities where the number of AIDS cases among IV drug users is low. Because IV drug users are not as mobile as the male homosexual community, the virus is spreading slowly among drug users — but, it is spreading, officials agreed.

The prevention campaign will hammer home to IV drug users that they should abandon sharing their "works," or hypodermic syringes and other apparatus, in what is an essential part of the IV drug users' culture.

This, in turn, fashions a political bombshell: if IV drug users are persuaded not to share their "works," they must be provided with cheap, or free, equipment — since most are not financially well off — if the deadly cycle is to be broken. No one wants to deal publicly with that issue at the moment.

In some states where hypodermic sales are controlled, users find it cheaper to buy illicit drugs than the "works." In states where there are no restrictions, users still don't carry their "works" because of fear of arrest.

Coca paste now entering North America

By Harvey McConnell

WASHINGTON — Highly toxic coca paste, a severe problem among young people in South America, is being imported with increased frequency into the United States.

"We are extremely worried about it," Carlton Turner, PhD, director of the White House office on drug abuse policy, told **The Journal**. Coca paste shipments seized in Florida contain about 50% cocaine, plus varying amounts of gasoline, kerosene, sulphuric acid, and other chemicals, he said.

Dr Turner's fears echo those expressed to **The Journal** 18 months ago by Nils Noya, MD, a Bolivian expert on cocaine use and addiction (**The Journal**, May, 1984).

Dr Noya said he was sure traffickers would turn to coca paste shipments to the US and warned about the terrifying and irreversible effects coca paste smoking has produced in South America.

(Coca paste — also cocaine paste or *pasta* — is the first extract from the coca bush leaf; the paste is refined into the white cocaine hydrochloride powder.)

In South America, coca paste is cheap to buy and is mixed with marijuana or tobacco into *basucos* or *pitillos*. Smokers become addicted rapidly and develop dysphoria, delusions, and a host of physical symptoms, and indulge in random violence. Deaths from overdoses, accidents, violence, and suicide are common.

Dr Turner said that with coca paste, "we are not only dealing with a substance which contains 50% cocaine, but something which also contains sulphuric acid, plus trace elements and lead from the gasoline and kerosene used in the conversion.

"The adverse effects can show in a short time, and the most worrying of all is that there is a danger of irreversible damage because it is a

(See Urine, p2)

Turner: toxic effects

Designer tag removed

WASHINGTON — Federal officials in the United States are going to stop using the term "designer" drugs. "I think by using the words 'designer drugs' we are glamorizing the heck out of it," says Carlton Turner.

In the future, "you are going to see the federal government stop using the term. We don't want to glamorize drugs." If it wasn't for the catchy term, he is sure the media would not have given the drugs such publicity.

The drugs should be called analogues, homologues, or drugs engineered to be drugs of abuse — "terms that don't give the connotation of desirability such as 'designer.' We don't know exactly what we will come up with, but we are working on it."

Drug vote caps inter-parliamentary meet

By Elda Hauschildt

OTTAWA — One thousand parliamentarians representing 102 nations are supporting both the proposed 1987 United Nations global conference on drugs (**The Journal**, July), and current efforts to develop a new UN convention on international drug trafficking (see page 3).

In one of only three resolutions passed here in September by the 74th Inter-Parliamentary Union (IPU) conference, delegates urge "parliaments and governments of all nations" to:

- "attack every aspect" of drug production, possession, trafficking, demand, consumption, and financing;
- recognize the "massive social and human problems" involved in international drug trafficking, and "reinforce the political will necessary" to tackle the problem;
- launch objective prevention programs;
- increase national and international assessments of the extent of production, trafficking, and use;
- strengthen international instruments "to control and contain" trafficking; and,
- increase efforts to eradicate illicit drug production through support for income replacement and crop substitution programs.

Member nations of IPU, which meets every six months, must have a parliamentary system of government, elected or non-elected; each nation's delegates are members of its parliament.

The drug resolution, a subsection of an International Youth Year resolution, was passed unanimously in a final plenary session of the week-long conference.

Earlier in the week, various delegations presented memoranda from their governments, and a draft resolution was prepared by a committee chaired by Allan Law-

(See IPU, p2)

INSIDE

NEWS

Briefly...

An adult pacifier

LANSING, Mich — A piece of pink acrylic on a clear, plastic loop is the latest panacea for compulsive smokers, overeaters, drinkers, and other drug users. The small, almond-shaped device — dubbed "Oral Cue" — is meant to be popped into the mouth whenever an unwanted urge strikes, says inventor Robyn Leary in *Monday Morning Report*.

Sweets — a first step?

LONDON — The practice of selling candy cigarettes to children is "despicable," says the National Society of Non Smokers here. Director Tom Hurst told *Alliance News:* "Through them, children are being conditioned to accept the handling and sucking of cigarettes as normal, grown-up behavior."

A real buzz

MEXICO CITY — A tipsy drinker imbibing in a *cantina* here may be in for the shock of his life. One of the services being hawked by destitute young men is a mobile, battery-operated electric shock treatment. The shocks — called *"toques"* — are supposed to sober up an inebriated patron with a jolt of electricity, says a report by *Reuters*.

Smokers fuming

JERUSALEM — Hundreds of Israelis rushed a cigarette factory in Tel Aviv recently, following a shortage of tobacco on store shelves. Police had to hold back an angry mob at a fenced barrier, while company officials threw cartons of cigarettes to help pacify the crowd, says *The Globe and Mail*. The cigarette drought, caused by a freeze on cigarette prices and strikes, has even encouraged ashtray-looting in restaurants, as hardened smokers look for butts anywhere they can.

A dram of aid

LONDON — A kit to help doctors treat problem drinkers may be available in Scotland next year, says *Doctor*. Called DRAMS (Drinking Sensibly and Moderately with Self-Control), the kit contains a record card for the physician, and a diary and a self-help book for the patient. The Scottish Health Education Group, which is promoting the scheme, is waiting now for the results of a pilot study at five centres in the Highlands of Scotland.

Tranqs Anonymous

LONDON — People addicted to minor tranquillizers need the support of self-help groups to curb their drug dependence, says the director of MIND, a national association for mental health here. Chris Heginbotham says that drug company profits from tranquillizers would be an ideal revenue source for the groups, and could also be used to "help GPs employ more counselling staff to help people with social problems." Mr Heginbotham has asked the department of health and social security to set up such groups, and provide information with prescriptions detailing adverse effects, says *Medical News*. MIND claims that 250,000 people in the UK are tranquillizer-dependent.

Western hemisphere conference called for

Cocaine 'epidemic' inevitable: expert

By Harvey McConnell

WASHINGTON — An international conference that would include representatives from Canada and western Europe is urgently needed to head off problems with cocaine now endemic in the United States, says 800-COCAINE telephone hotline co-founder Arnold Washton, PhD.

Dr Washton told **The Journal** he had lengthy discussions with British Foreign Office Undersecretary David Mellor during a recent fact-finding mission to North America.

Dr Washton says: "No country, certainly not in western Europe and not Canada, is immune to cocaine problems. I think if something isn't done, it is inevitable they will have the same experiences we have had; the epidemic will grow to such a point it will take a large toll on their populations."

The hotline does not operate from Canada, but calls have been received from treatment people in Canada.

Dr Washton, also director of addiction research and treatment at the Regent Hospital, New York city, said Canada and western European nations, especially Britain, France, Italy, and West Germany, are beginning to see the start of cocaine problems, "and I think would benefit greatly from our experiences.

"I think they suffer from the same kind of blindness we suffered from even three years ago. There was a big problem out there, it was not readily observable to the public, and the experience like the hotline was something to bring it out."

The proposed conference would bring together people working in the drug and alcohol field, family physicians, and others in the mental health field, in an international centre such as Geneva.

"Just the existence of the conference will make the statement that cocaine is an international problem. We hope other countries can benefit from our experience, and perhaps through coordination of our efforts legally, politically, and otherwise, maybe we can do something to combat it," Dr Washton added.

Dr Washton estimates the peak of cases in the US will not be seen for another two to five years. The recovery rate for cocaine addicts will probably equal that of alcoholics.

Washton: no country immune

CMA resolution supports smoke-free flights

By Betty Lou Lee

OTTAWA — Smoking should be banned in all Canadian commercial aircraft, the Canadian Medical Association (CMA) recommends.

It also wants smoke-free areas in public buildings.

The resolutions at the annual meeting of the CMA general council here are the latest in the association's battle against smoking, which began in 1954 with a public warning on the hazards involved.

One of the doctors who still smokes tried to get the airplane resolution amended to cover flights of less than two hours.

"On a seven-hour flight to Europe, they'd be peeling us off the ceiling," he said. But, he got little sympathy and even less support for his amendment.

Another physician suggested airline attendants should give out small packages of nicotine chewing gum instead of small packages of candy.

The doctors also expressed their "approval and appreciation" of pharmacies that have stopped selling tobacco and/or rejected promotion of tobacco products (**The Journal**, April, 1984; March).

They were told that 500 of 5,500 drug stores in Canada no longer sell tobacco, and 1,500 don't promote it, even though tobacco products used to account for 13% of their gross sales.

The council also sounded a warning to doctors who might be involved in supplying drugs to athletes to improve their performance (**The Journal**, September).

It said "deliberate provision to an athlete of a substance, as defined by the International Olympic Committee's medical commission, for the sole purpose of enhancing athletic performance is an unacceptable practice."

It stopped short of calling it "unethical practice," which would have more serious connotations to any medical regulating body.

But, it also called on sports authorities to ensure that athletes are not penalized for using medication that is medically required. Insulin for diabetes or antihypertensives for high blood pressure are examples.

Urine screening 'contentious' in US industry

(from page 1)

potent neurological toxin."

Not only would there be health problems, but also, based on experience in South America, damage can be so severe that, realistically, thought would have to be given to "where you might have to place people for the rest of their lives."

Dr Turner said one of the ironies is that increased law enforcement efforts in South America, including restrictions on essential supplies of ether — essential to convert paste to powder — have caused the influx of paste shipment to Florida laboratories. One of the needs now "is to train law enforcement dogs to hit on coca paste."

He is afraid people won't be deterred by coca paste: "People who accept cocaine and marijuana use will probably have no compunction at all in using coca paste."

Dr Turner said that in 1977 he warned that perhaps 10 or 15 years down the road coca paste might become a problem in the US. But, little or no research was done then "because of the NIH (Not-Invented-Here) syndrome. We have got to rediscover it."

Turning to the growing use of urine screening in industry, Dr Turner told the annual conference here of the Alcohol and Drug Problem Association of North America, it is a contentious issue, and some of the objections to it are legitimate. He believes there should be strong agreement on lines of communication to workers.

"I think there should be protection of individual rights by insuring that the test is a reproducible test, thus preventing people who are not users from being labelled users. I think there needs to be a general review of the system as a backup to insure that a positive is really a positive."

On alcohol, Dr Turner said that during the past nine months there have been definite changes in the way it is being advertised in the US: fewer athletes are being used to promote alcoholic beverages, and changes have been made in marketing on college campuses and in the message that alcohol can make one fit better into society.

Dr Turner said discussions have been held with advertisers, the media, and other interested parties. Much of the push has been generated "by hurt and anger, and unless you deal with hurt and anger head up and straight forward, you are not going to get away from sanctioned legislation for very long."

While he personally does not favor trying to change things through legislative approaches, Dr Turner says such approaches may be made through Congress next year.

Group wants own drug meeting in 1987

IPU backs publicity for prevention

(from page 1)

rence, a Canadian member of parliament. Mr Lawrence was also the rapporteur on the issue at the plenary session.

The final resolution recommends IPU hold a 1987 conference on drug trafficking in the western hemisphere, in cooperation with the UN and the Latin American parliament.

Countries are asked to "prevent or seize earnings from illicit trafficking" through improvements in banking legislation or development and implementation of confiscation laws, and to "harmonize" penalties for trafficking, utilizing extradition processes "to the fullest."

Governments who have not yet ratified the UN Single Convention, the amending 1972 Protocol, or the 1971 Convention on Psychotropic Substances are asked to do so. IPU member parliaments are urged to establish inter-governmental, inter-parliamentary mechanisms to study and exchange information on different legislative, executive, and judicial action; encourage professional training for those in treatment positions; and, establish drug rehabilitation centres.

Roger Hill is deputy director of the Parliamentary Centre for Foreign Affairs and Foreign Trade in Ottawa and a consultant to the IPU conference. He told **The Journal** the need for public awareness of the drug problem was prominent during the conference, as well as in the final resolution.

The resolution urge those involved with the press, electronic communications media, radio, cinema, and television "to recognize their public responsibilities . . . in particular, to emphasize that at no level is drug abuse acceptable."

THE JOURNAL

— next month —

- *Women, grieving, and drug abuse*
- *Benzodiazepines — another view*

NEWS

Reports from 34th International Congress in Calgary

Debate simmering on international drug treaties

By Anne MacLennan

CALGARY — Hasty attempts to counter increasing world drug problems with more international treaties will be counter-productive, says a long-time legal adviser to the United Nations and expert on international drug law.

"Policy makers should learn a lesson from the legal history in this field," Alfons Noll said here. Mr Noll was legal adviser to the UN Division of Narcotic Drugs and secretary to the UN Commission on Narcotic Drugs from 1971 to 1979.

It was "precisely the abundance of international treaties" developed since 1912 that prompted states to adopt the 1961 Single Convention on Narcotic Drugs as "a generally-acceptable international convention." Although that convention was amended (by the 1972 Protocol) and an additional one developed — the 1971 Convention on Psychotropic Subtances — policy makers should be wary of adding to those three, he said.

Mr Noll suggested a proposed new convention aimed at wiping out the enormous profits in drug trafficking, and now in draft form (**The Journal**, April), risks "duplicating, overlapping, and conflicting" with the existing treaties.

"Furthermore, it contains concepts which are questionable in their nature and raise serious doubts about the acceptability of such provisions by governments."

Most alarming is the stipulation in the draft that drug trafficking is a "grave, international crime against humanity." That phrase is "too far-reaching and inappropriate," having been used previously in a very limited way to cover such crimes as genocide, trade in slaves, and war crimes.

Again, he said, history holds a lesson: it could be a decade before the proposed new convention enters into force and then, only if sufficiently large numbers of states adhere to it.

Mr Noll said the existing treaties would, in the short term, be sufficient if they were "properly and fully implemented" by all states. (At the beginning of 1985, of 160 member states in the UN, 115 were parties to the Single Convention, 78 to the Single Convention as amended, and 78 to the 1971 Convention.)

Noll: duplication

He said individual states should also enact and implement even stricter and more severe provisions than those provided for in the treaties, if necessary.

"The call for, and the recourse to, the adoption of new international measures should not serve as a subterfuge to cover up deficiencies in the field of national control measures."

For the long term, he said, policy makers should try to improve drug control through revision and amendment of the existing treaties and, possibly, amalgamation of the three into one covering both narcotic and psychotropic drugs.

"It might also be useful to provide for the merger of the existing three 'secretariat services,' ie, the UN Division of Narcotic Drugs, the International Narcotics Control Board, and the UN Fund for Drug Abuse Control, into a single secretariat for international drug control," he said.

Mr Noll, now legal adviser to the International Telecommunication Union, re-entered the continuing debate on the efficacy of the international drug treaties at the 34th Congress here of the International Council on Alcohol and Addictions.

The debate stems largely from the apparent failure of the system to block the escalation of global drug abuse and trafficking. While there is some agreement that commitment to the treaties by all states could improve the situation, even that may not be enough, some believe.

Viz Navaratnam, director, National Drug Research Centre, Penang, Malaysia, read a paper on the subject prepared by Datuk Rais Yatim, Malaysia's minister of information and president of PEMADAM, the national association against drug abuse.

The treaties are nothing more than "diplomatic niceties," he said.

"From our regional and national perspective, the international conventions are inadequate and, effectively, have had minimal impact on our drug control efforts. At best, they have merely provided the basis of a framework.

"To achieve effective drug control, and for international treaties to work, there is an urgent need to review, amend, or, if necessary, enact new instruments which then can replace existing ones, that address practical realities and needs," the minister wrote.

He said: "The subtle, yet crude attempts being made to ensure free availability of synthetic, manufactured psychoactive agents, under the pretext they are needed for therapy, is becoming glaringly obvious to several developing nations.

"Several 'advanced' countries have resisted the implementation of stringent control measures on them. Yet, it was these very nations who brought tremendous pressure to bear on several of our regional countries to ban opium cultivation overnight. Several scientists have argued it was this hasty ban on opium that lead to widespread availability of heroin in our regional boundaries and globally."

Navaratnam: resistance

Treatment service a balancing act: Marshman

By Elda Hauschildt

CALGARY — Providing treatment services in the addictions field is a balancing act, and changes in the system can only be made well when all the forces at work are kept balanced, says the president of the Addiction Research Foundation in Ontario.

"Although the types of forces at work are similar, even in widely-separated jurisdictions, the color and balance of these forces may be highly variable — even within a single jurisdiction," Joan Marshman, PhD, told the 34th International Congress on Alcohol and Addictions here.

Marshman: quality of life

"It is, therefore, not surprising that there is a tremendous diversity in treatment services, both within and across jurisdictions. Nor is it surprising that even necessary and appropriate changes in treatment systems can be made successfully only when we maintain the multiple forces in equilibrium," she said.

Dr Marshman suggested that while national and regional policy and legislation define "the boundaries" of formal treatment services to varying degrees, in turn they are shaped by forces such as history and culture, law and regulation, public health, knowledge and experience, the economy, and ideology and politics.

These forces, "which are not separate and discrete, but clearly interactive," are so familiar to those in the addictions field, "we sometimes fail to include all of them in our change-directed thinking," Dr Marshman said.

"Although national and state/provincial policy and legislation may define the generic boundaries and constraints of treatment service delivery, the character of the treatment system — or, in some cases, non-system — is more commonly defined at the local or regional level," she said.

Various factors shape plans at this level too: external controls, such as policy, legislation, funding, and accreditation; the epidemiology of alcohol and other drug problems in the community; community culture; service organization and delivery models; and, program evaluation.

Against such a backdrop, Dr Marshman said: "It is easy to understand why the target populations for treatment services differ from one jurisdiction to another."

Expectations from treatment also vary, with governments wanting "hard data" indicating decreases in demand for illicit drugs, in social and family disruption, in utilization of government-funded services and benefits; and indicating gains in industrial productivity and in minimum per-client cost to government.

"Treaters" for their part, Dr Marshman suggested, "may give further emphasis to quality-of-life expectations."

The disadvantages of treatment must also be considered: for the client — "a temporary destabilization of one or more area of life functioning;" and for governments — the prerequisite of public resource investment in treatment services with an indeterminate wait for public savings.

"In the case of alcohol and tobacco, there may be a compounding concern that, as heavy drinkers and smokers reduce their consumption, government tax revenue may be significantly diminished unless there is a compensatory shift among other users or in the tax structure," she said.

Range of services better — in Canada

CALGARY — Canada is doing a better job of providing a range of treatment options for addiction patients than the United States, says a US psychologist.

"You in Canada are doing a much better job of resisting the move to intensive, in-patient treatment — especially to private, intensive, in-patient treatment," William Miller, PhD, a clinical psychologist at the University of New Mexico, said.

"There are different methods for treating alcohol and other drug abuse. I feel much more optimistic about the kinds of programs that I see in Ontario and Alberta than I do in my own country," he told a plenary session here at the 34th International Congress on Alcohol and Addictions.

Dr Miller was responding to a question from the audience.

Economic viewpoint could aid addictions policy

CALGARY — An economic perspective is critical to any evaluation of policy in the addictions field, an Irish economist says.

In general, economists favor using any available mechanism, such as the taxation of alcohol and tobacco, "to make people bear the full costs associated with their consumption patterns," said Brendan Walsh, PhD, professor of political economy at University College, Dublin.

Understanding the principle of "consumer sovereignty" — the idea that the range of goods and services produced and supplied to a market reflects the wishes of the consuming public — is one example Dr Walsh gave to the 34th International Congress on Alcohol and Addictions here.

But, he said, economists recognize that consumers often lack the information and knowledge needed to understand the consequences of different patterns of consumption. Sometimes, such information problems "can be overcome by insurance, guarantees, or a harmless process of trial and error."

Other times, "there seems to be no substitute for a learning process that can be painful or even destructive of life and limb.

"This risk seems to be particularly high when new substances are being clandestinely introduced into a culture that has yet to evolve mechanisms of social control," Dr Walsh said.

"In situations of this type, there is a logical case for interfering with consumers' freedom in order to help them avoid courses of action they would later regret."

More could be done "to bring home to the smoker and those who abuse alcohol the increased medical costs that these consumption patterns generate. Loadings on life insurance and health care policies are one approach," Dr Walsh said.

"I think it is likely that public opinion will favor an increasingly harsh approach on these issues. When combined with increased efforts to make people aware of the consequences of substance abuse, this seems a reasonable philosophy."

Dr Walsh emphasized it is important to assess the factors underlying "the demand for alcohol, tobacco, and drugs by the public, and the nature of the supply of the market.

"It is also important to try to gauge the relative magnitudes of the costs imposed on society by the abuse of these substances and the effectiveness of alternative approaches to reducing these costs.

"We shall never be able to eliminate these costs completely, but we must strive to contain them to acceptable proportions with a minimum diversion of resources from competing uses."

Economists acknowledge the benefits of taxing tobacco and alcohol, but there is less agreement about whether taxation reduces demand, he added.

"While tax revenue is welcome from a fiscal point of view, it deprives consumers and their households of purchasing power that may be needed urgently for essentials."

NEWS

Canadian military forces tackle alcoholism

By Betty Lou Lee

OTTAWA — A mini-army within Canada's armed forces is involved in preventing and treating alcohol and other drug abuse among 80,000 military personnel, their 250,000 dependents, and 36,000 civilian employees of the department of national defence.

Each of 69 bases and stations and 1,000 military units now has a part-time drug education coordinator. There are seven full-time regional coordinators and three others full-time at Ottawa headquarters.

Six regional alcoholism rehabilitation clinics with an average annual patient load of 650 operate across Canada and in West Germany. After the 28-day, in-patient treatment program, there is at least a one-year follow up program.

Lt Col Jacques Roy, MD, head of prospective medicine in the directorate of preventive medicine, national defence, outlined the program at the addiction, alcohol, and drug-related problems section of the annual scientific meeting here of the Ontario Medical Association.

With the increase in illicit drug use in society in general, a drug education program was begun in 1971 but, since 1979, its emphasis has been on alcohol, which presents the biggest problem, Lt Col Roy said.

A comprehensive survey in 1982, released in 1984, showed 90% of people in the armed forces drink alcohol, 24% of them three or more drinks a day. Six percent drink more than seven a day.

Some 37% reported using marijuana/hashish in their lifetimes, 14% within the last year, and 7% within the last month, which Lt Col Roy said was the same as the general population. One percent use cannabis almost daily.

He was under orders not to answer media questions, so the cost of the Drug and Alcohol Prevention Program (DAPP) was not available.

And, although he said that "both price and accessibility of alcohol are two important considerations in the military setting," he gave no indication of how these were being addressed by the military.

Two weeks later, a provincial court judge in Ottawa called on the military to restrict the sale of cheap alcohol on its bases. He was commenting during the sentencing of a corporal who twice assaulted his wife while drunk.

Although an armed forces spokesman said drinks were not much cheaper on the bases than in downtown hotels, a *Canadian Press* story said beer was $1.05 at an Ottawa base, compared to about $2.05 in the city, and liquor $1.10, compared to $2.75.

Lt Col Roy said an intensive, 24-hour life skills education program is part of every recruit's training. It was adapted from the United States Navy, which, in turn, adapted it from the Donwood Institute in Toronto. A three-year follow-up of this program is underway.

"The Canadian Forces is the only military organization anywhere with such a program at the primary prevention level," he said.

At the field unit level, there are general awareness education programs and supervisor training to recognize and deal with alcohol and drug problems.

There are employee assistance programs for civilian employees.

Pilot projects in secondary programs to bridge the gap between awareness education and rehabilitation are being evaluated in West Germany and Victoria, British Columbia. These are aimed at members of the forces involved in "alcohol-related incidents."

Lt Col Roy said 75% of those who complete the rehabilitation programs "remain abstinent or return to drinking without overt problems.

"However, recovery from alcoholism is not just the maintenance of abstinence, although that is the most easily measurable (although in some cases the most suspect) statistic."

So, early next year, the department will begin an evaluation project at each of the clinics "to determine whether the patient is actually functioning better in his or her daily life."

RESEARCH UPDATE

. . . will return in November

Narcotics Anonymous: AA's child

MONTREAL — When Narcotics Anonymous (NA) was founded in 1953, it received from Alcoholics Anonymous (AA), "the greatest thing AA could give — 12 steps of recovery and the 12 traditions," says Bob R., an NA trustee.

He told AA's 50th anniversary convention here that NA's history "is like a roller coaster."

In the past, he explained, many states in the United States declared it unlawful for addicts to associate with each other. "That stymied some of our big population areas," said Bob R. "But, authorities began to comprehend there was a disease of addiction, and eventually restrictions began to diminish."

NA holds meetings in 23 countries, including Canada.

AA and NA cooperate on referrals. In telephone hotline systems run by the two fellowships, each has a directory of names from the other service for referral purposes.

The nature of alcoholism and drug addiction runs parallel, Bob R. told the convention. "That's why cooperation with AA is so important. We are not here to compete. We are only here to help the addict who still suffers."

John L. warned that AA members have no right to tell people to throw away prescriptions or disregard doctors' orders. "We are not doctors. Serious consequences arise when we meddle in things which are none of our business."

John L. added: "Nothing is said in AA literature about smoking funny cigarettes, taking pills, shooting up, or sniffing cocaine. AA is clearly for alcoholics. We have learned from experience there is no way to make non-alcoholics into AA members."

However, he said that those with dual addictions can be sponsored in AA.

I'm sick of 'doctors know nothing' theme

By Wayne Howell

Call this a polemic, call it a diatribe, call it what you will. But, I am sick and tired of people saying that doctors know nothing about alcoholism. And, that is despite the fact that, although I attended medical school, I am not an apologist for the medical fraternity and am not a member of any medical association.

I encountered the 'doctors know nothing about alcoholism' line at the first alcohol and drug conference I ever attended. The perpetuator of that line was, not incidentally, a distinguished professor at a medical school. The assertion did not affect me one way or the other since I was used to that kind of thing; I was used to hearing that doctors know 'nothing' about a variety of subjects, including childbirth, the therapeutic benefits of spinal manipulations, and pre-menstrual tension.

What affected me was the response to this assertion: it was greeted not only by applause, but cheers. The response from the audience — made up of the usual mix of psychologists, social workers, and professional and lay counsellors, some of whom had had a personal alcohol problem and some of whom had not — was emotional to the point of being cathartic. In other words, they loved it.

After the applause and the cheers had died down, the professor got down to specifics: there was no course on 'alcoholism' given at any Canadian medical school. So, *res ipsa loquitur*, to borrow a term from the legal fraternity, doctors know nothing about alcoholism. More applause and cheers.

I have heard many a variation on the 'doctors know nothing' theme since that day more than a decade in the past, and I have seen many a variation on that theme reported in **The Journal**. But, I always remember my initial reaction to that comment: amazement — not so much to the comment, but to the visceral reaction to it.

Let us first deal with my reaction. As I said before, I was used to hearing about areas of human activity, behavior, and pathology of which doctors knew 'nothing.' But, I was a little surprised that *this* was an area of which doctors knew nothing, since I had heard so much about the deleterious effects of alcohol during my medical training.

I remembered my first teacher of internal medicine, a man who was the epitome of the wise old clinician. "Boys," he said, (and we were all boys; the equal-opportunity era was then in its infancy), "if there has been one thing that my life in medicine has taught me it is this: the major medical problems in our society are caused by alcohol, obesity, and tobacco."

That was just the start; from then on it was alcohol, alcohol, alcohol, all the way — in medicine, obstetrics, surgery (yes, even surgery), psychiatry, and preventive medicine. Alcohol as a major factor in pathology — both physical and psychic —was ubiquitous. It was ubiquitous in the classroom and on the wards, so much so that I thought I knew something about it after four years.

What hubris, as the ancient Greeks would say. How could I know anything about it, if it was not officially on the curriculum? Thank God, the professor set me right: there was no course on 'alcohol' or 'alcoholism,' therefore, *ipso facto*, I knew 'nothing.'

Whatever lessons I learned from imbibing vodka-and-orange juice on an empty stomach at 8 am so that my physiology classmates could analyze my alcohol-excited gastric juices through a naso-gastric tube, and whatever lessons I learned from my apprenticeship as a 'doctor' on a Native reserve during the summer break were all for naught. Alcoholism wasn't listed in the curriculum.

Applause and cheers

As I said, I was not so much amazed by the assertion that doctors 'know nothing,' as by the response to it.

And, I must confess that the applause and cheers intimidated me to the point that I did not rise from my seat and conduct a spirited defence of the medical profession, although I dearly would like to have done so. I sensed that I was in a no-win situation; whatever eloquence I would be able to muster would be of little use against this howling mob that had just witnessed one member of the medical profession fall on his sword murmuring '*mea culpa*,' and was eager for fresh blood.

It was only later, when I talked to one of the more enthusiastic applauders, that the whole thing began to make sense to me. This man, a former alcoholic and a prime mover in a provincial alcohol rehabilitation program, expressed his dissatisfaction with the medical profession in no uncertain terms.

Doctors, he said, tried to cure alcoholism with pills of one kind or another and, by so doing, they just added to the problem by making a simple addiction into a complicated one. He had examples of this kind of practice. He was a bitter man and I suppose he had a right to be.

But, as he talked I realized that his anger and disappointment did not arise because of any fundamental antipathy toward the medical profession — on the contrary, it arose because of a touching faith in it.

Anger and disappointment

He was bitter not so much because doctors had tried to cure alcohol problems with pills, but because the pills had not worked. The Official Healers (official in the sense that they are sanctioned by provincial licensing bodies) had let him down. His faith in the powers of modern medical science was great, and so his disillusionment following the failure of the therapy was much more profound than if he had sent his clients to a herbalist, an acupuncturist, or a priest.

He expected that the Official Healers should be able to solve his clients' problems. But, the New Alchemists (the doctors with their arcane Hoffmann — La Roche potions) were no more effective in turning his clients into abstaining family-men than the old alchemists were effective in turning lead into gold.

His bitterness arose in good part out of the fact that he respected the medical profession and expected great things of it, and so he was all the more disappointed when the treatment was ineffective to the point of being deleterious. He had believed in the Emperor of the Healing Arts and was thus doubly vexed and aggrieved when he discovered the Emperor had no clothes, or rather shabby raiments at best.

Hence, his spontaneous and heartfelt contribution to the incredible Bronx cheer that erupted when a member of the sacrosanct Official Healing Profession indicted the entire healing tribe as 'know nothings.'

My conversations with him, and people like him, helped me put things into perspective. I was not convinced that 'doctors know nothing.' In fact, I was convinced that in many cases doctors actually know too much, and as a consequence they take an overly casual or overly cynical approach to alcohol problems.

In other words, doctors are 'burn-out' cases that got burnt out before they even got started. And, it is because of this that doctors' therapeutic interventions are often fitful and clumsy — doctors tend to carry-on with bland homilies until an abnormal liver test pops up, at which point they announce: "If you keep on drinking like this, you are going to kill yourself." Needless to say, this does not do an insecure, self-destructive patient much good.

What will do that person some good? Who will do that person some good? There are all sorts of therapists, counsellors, and such like who can make a difference — not necessarily because they 'know something,' but just because they are the right person to intervene — on a very personal level — at the right time.

More power to them, I say. But, I also say this: if you want to whoop and holler at the medical profession, do not do it because 'alcohol and other drug abuse' does not appear on the curriculum. And, do not do it out of spite, because the profession does not, or cannot, deal with 'problem cases' any better than you can.

God knows, the profession has its faults, but in my opinion, 'know nothingness' or a lack of knowledge about the extent of, intricacies of, and subtleties of, alcohol abuse is not one of them.

Anti-drug tactics miss point: Peele

By Betty Lou Lee

HAMILTON — Laws against drugs not only don't work, but they also often exacerbate abuse. The emphasis should be on any unacceptable behavior that accompanies drug use, says social psychologist Stanton Peele, PhD.

Drunk driving laws are based on blood-alcohol level, but many drunk drivers are caught because they are driving so carefully police notice them, he told the 26th annual Institute on Addiction Studies here.

"Why not just have laws against driving recklessly and killing people? Who cares why they do it."

The concept that it is the substance, rather than the person using it, who is responsible is used successfully in law courts. "The more society believes alcohol is an excuse for misbehavior, the more misbehavior there will be," Dr Peele said.

In cultures where misbehavior after drinking is neither expected nor condoned, such as among Jews and Chinese, its incidence is low.

In a study of 17,000 arrests in New York city's Chinatown, between 1933 and 1949, not one was reported to be alcohol-related. "They don't go for getting drunk and breaking the place up .... They rule out loss of control."

Dr Peele, of Morristown, New Jersey, has been studying addiction for 15 years, and is the author of *Love and Addiction* and *The Meaning of Addiction*.

He scoffed at such tactics as offering free public transit on New Year's Eve. When it happened in New Jersey, 27 train cars were vandalized, and passengers terrorized. "The logic was to keep them off the road, the message was drunks had a place to party."

The suggestion that parents agree to fetch their children, no questions asked, if they call and say they've been drinking, gives the message "kids can go out and get drunk, and we have to save them."

Attempts to control importation or sale of any substance have always led to an increase in its abuse, he said.

"In 1972, (US president) Nixon declared war on cocaine, and in 1985, there's not only more cocaine than ever before, but it's cheaper.

"The largest peace-time naval operation in US history is now in the Caribbean to prevent the import of drugs .... Do we really believe the only way we won't have a nation of drug abusers is to blow up South America?"

Dr Peele said one of the best ways to prevent addiction in children is to give them some values: what's good for them and their bodies, a sense of accomplishment, self-reliance, opportunities to overcome adversity, and a sense of what is right and wrong.

"The main lesson in life a child has to learn is that it's okay if you make a mistake, you can still succeed .... We got the wrong message, that you should hold their hand and guide them so they will not suffer any problem.

Peele: the wrong message

"The best way to prepare a child for addiction is to prevent him from having any experience along the road.... Sometimes butting out is a great parental skill."

GILBERT

'A curious feature of the move to regulate smoking in the office workplace in Toronto has been the absence of opposition from the tobacco industry'

Passive smoking: II

By Richard Gilbert

Last month, I updated evidence on the health effects of passive smoking. Here, I shall describe what is happening in the province of Ontario, where in the absence of province-wide action by the government, cities and towns have been the focus of attempts to provide protection to citizens from other people's tobacco smoke.

Ontario municipalities began passing comprehensive legislation concerning smoking in public places in 1976, some years after a start had been made in the United States. Ottawa was the first in Ontario, followed six months later by Toronto. Now, 24 of Ontario's largest 110 municipalities regulate smoking in all or most of the public places that non-smokers are likely to be concerned about.

Nils Jensen, a law professor at Carleton University in Ottawa, has surveyed the 110 municipalities and categorized them according to whether or not they have a public smoking by-law, and whether or not the by-law is limited or comprehensive. His results are set out in the table below.

The table shows that more than three-quarters of large Ontario municipalities have some kind of legislation limiting smoking in public, but fewer than half of the medium-sized and fewer than a quarter of smaller municipalities have this kind of by-law.

The final column of the table shows that more than half of the councils that have not limited smoking have nonetheless banned smoking in their council chambers. Mr Jensen commented that personal health seems more important to these councillors than public health.

Most of the 24 comprehensive by-laws have been passed since 1979, when a panel of three judges of Ontario's divisional court gave municipal councils reason to believe they had the power to regulate smoking.

Enabling legislation

Throughout Canada, municipalities may do only what provincial statutes permit them to do, as interpreted by the courts. Prior to 1979, Ontario's cities had relied on the following words in the Municipal Act: "*Every council may pass such by-laws and make such regulations for the health, safety, morality, and welfare of the inhabitants of the municipality in matters not specifically provided for in this Act as may be deemed expedient and are not contrary to law ....*" (now part of Section 104 of the Act).

Municipal solicitors, including those of Ottawa and Toronto, had taken the conservative position that these words did not confer authority to regulate smoking. A few cities nevertheless passed by-laws in spite of their solicitors' advice.

The three judges heard a challenge to the legality of Toronto's by-law by Helen Weir and Top Drug Mart Ltd. They ruled: "Once the preamble [to the by-law] is accepted as factually correct, then it would seem that the municipality is empowered to pass a by-law such as this to regulate smoking."

Delegation illegal

Toronto's by-law was struck down on other grounds. The judges agreed with the complaint that the city council had no authority to delegate responsibility for enforcing a by-law to building owners, or other managers of the public spaces where smoking was being prohibited. Council immediately amended the by-law to assign enforcement to city employees.

A curious sidebar to the story of municipal efforts to regulate public smoking in Ontario concerns the city of Sarnia — on the United States border at the southern tip of Lake Huron. Alone among Ontario cities, Sarnia applied for and received special enabling legislation from the province to regulate smoking. The application was made before the Top Drug Mart decision.

The resulting provincial statute certainly gave Sarnia what it asked for — the power to regulate smoking in parts of buildings to which the public has access — but, in appearance, the power is more restrictive than that conferred by the judges' ruling. The statute was enacted after the ruling. It probably has the effect of limiting Sarnia's ability to legislate in this area more than that of any other Ontario municipality.

Private places

Municipal solicitors interpret the judges' ruling to mean that Ontario municipalities, with the probable exception of Sarnia, may pass by-laws to regulate smoking in private places where this is ". . . for the health, safety, morality, and welfare of the inhabitants ...." At present, only the city of Toronto seems interested in extending the regulation of smoking to private places. In Toronto, the concern is to control smoking in office workplaces.

In June this year, Toronto city council voted 18 to 1 to proceed toward passing a by-law during 1985 that, as far as our legislative authority permits, would regulate smoking in the workplace in a manner similar to the ordinance enacted by the San Francisco board of supervisors in 1983.

I described the provisions of this ordinance and the history of its passage in my March, 1984 column. In essence, it seeks first to reach an accommodation between smokers and non-smokers in each office workplace by requiring employers to attempt to adopt and enforce a policy satisfactory to both interests. If policy cannot be agreed upon, smoking must be banned.

Substantial paradox

The city of Toronto is faced with a substantial paradox in devising such legislation. The council's solicitor advises that the council has the power to be much more restrictive than San Francisco, in that smoking could be banned in all office workplaces in Toronto. However, there is no authority to legislate in the sensitive, flexible, and, highly successful manner of San Francisco. The problem lies partly in the Toronto council's inability to delegate. Another part of the difficulty is that, without specific authority to require employers to adopt policies, a requirement that they do so, or attempt to do so, might very well be struck out by a court on the grounds that employers would not have clear direction as to how to conform to the requirement.

Special provincial legislation has been requested that would remove these difficulties, but it may take two or three years to achieve. In the meantime, interested parties, including Garfield Mahood of the Non-Smokers' Rights Association, are busy meeting to work out how Toronto city council's wish can best be met.

Workplace prohibition

One possible solution is to follow some of the provisions of the state of Minnesota's Clean Indoor Air Act (1975). Essentially, these prohibit smoking altogether at places of work, with specific exemptions. The exemptions include private, enclosed offices occupied exclusively by smokers, and smoking lounges that constitute no more than a small percentage of the total space available to employees.

These provisions can probably be refined to conform to the legislative requirements within Ontario and to cope with Toronto city council's intention to regulate smoking in office workplaces only. The result would be less satisfactory than what San Francisco has done. Such a by-law could nevertheless be justified on the grounds that some action is better than none, and that action by Toronto might spur the provincial legislature to give Ontario municipalities the authority to regulate smoking in the workplace in a sensitive manner.

A fly in the legislative ointment could be the new minority Liberal government of Ontario, which has a substantial political base among the tobacco farmers in the south-west of the province. The previous (Conservative) government was already showing signs of succumbing to their concerns about declining cigarette consumption. Automatic increases in tobacco tax indexed to inflation had been put into abeyance.

Industry silent

A curious feature of the move to regulate smoking in the office workplace in Toronto has been the absence of opposition from the tobacco industry. The industry spent millions of dollars in 1983 in an almost-successful attempt to sabotage the San Francisco ordinance. It appears to have taken no action in Toronto, even though the likely result will be a very restrictive by-law.

Status of Ontario Municipalities with Respect to the Regulation of Public Smoking

Population of municipality	Number in category	Number of municipalities with: *Comprehensive by-law*	*Limited by-law*	*No by-law*	No by-law, but ban in Council Chamber
>100,000	16	8	5	3	3
25,000-100,000	37	12	4	21	10
10,000-25,000	57	4	6	47	24

Notes:

1. Ontario's 39 upper-tier municipalities are not included. Restricting public smoking has become a prerogative of cities, boroughs, and towns.
2. A comprehensive by-law regulates smoking in public areas of all or most of the following: retail stores, hospitals, reception areas and service lines, elevators, theatres and other places of public assembly, and restaurants.
3. A limited by-law regulates smoking in some but not most of the places detailed in Note 2.

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Cutting cigarette ads would help

Richard Gilbert raises some important issues in his column (August) on the effects of advertising on cigarette smoking.

Ms Jacobson's (not Johnson) book, *The Ladykillers*, is interesting and reasonably well-researched, but must ultimately be judged as a popular rather than scientific work. No serious researcher would argue that advertising is the sole or even most important cause of cigarette smoking. Clearly, advertising is at most a contributory cause of increases in consumption, and may function more to legitimize a behavior that is increasingly perceived as deviant.

Simple correlational studies that purport to link advertising and smoking are not very useful. However, other approaches can be employed, for example, time series studies and quasi-experimental research, particularly in Third World countries. Even so, stabilization of smoking among women during a period of increasing advertising is not inconsistent with a causal role for advertising, particularly since smoking declined among men during this period. In fact, while the proportion of women who smoked declined, consumption per smoker increased.

Advertising is only one component of the marketing process, and researchers might be well-advised to focus on all aspects of marketing. Distribution, pricing, and labelling are all candidates for investigation.

Perhaps the most important point mentioned by Dr Gilbert is the suppression of information on the health effects of smoking in publications that include cigarette advertising. In this case, advertising may keep people smoking who otherwise might have quit. Advertising may be only one of a number of factors that encourage smoking, but it is one that is easier than many others to change and so deserves our attention. If advertising accounted for only 5% of smokers, or for only a 5% increase in consumption among current smokers, its removal would still have a significant effect on public health.

Ferrence: other approaches

Roberta G. Ferrence
Prevention Studies
Addiction Research Foundation
Toronto, Ont

(Ed note: How Bobbie Jacobson became Bobbie Johnson (Gilbert, August) is a mystery to all at **The Journal**. *We apologize to her and to readers.)*

Policy report praised

Your summary of the program policy committee of the Addiction Research Foundation report on the Drinking/Driving Dilemma (March) is the most well-thought-out, concise treatment of the issue I have ever read. Would you be kind enough to send me a reprint of the article? Thank you.

I. Kalicinsky, MD
Seven Oaks Medical Centre
Winnipeg, Man

(Ed note: A copy of the issue has been sent to you.)

AA's spirituality

Joan Hollobon's article on AA's 50th anniversary (August) reveals that AA (Alcoholics Anonymous) despite its 50 years on the alcoholism scene, has more education to do. In particular, AA apparently has to educate reporters for addiction research foundation journals who write feature articles on AA.

At the risk of some redundancy, please be advised that AA advertises itself as a spiritual program and not a religious program. Its beginnings were not "unabashedly religious" as reporter Hollobon mistakenly reports, but unabashedly spiritual.

Furthermore, meetings of AA vary greatly. While some meetings end in The Lord's Prayer, many do not. AA does not require the "admission of alcoholism," and requires only that members have a desire to stop drinking. A suggested (but not required) step is the admission that one is powerless over alcohol and one's life has become unmanageable.

While the AA program as a spiritual program will indeed show similiarities to other spiritual paths, including those of formal, organized religions, these similarities should not be taken as identities. AA is, in part, a spiritual program not a "religious" one, its meetings are meetings and not "services," its groups are groups and not "congregations," and its processes are processes and not "liturgy," as reporter Hollobon mistakenly implies.

Perhaps it would be helpful for reporter Hollobon and your readers to bear in mind the following: "The World is round an orange is round; the World, alas, is not an orange."

John Wallace
Director of Treatment
Edgehill Newport
Newport, Rhode Island

OMA honors Hollobon

OTTAWA — Joan Hollobon, a contributing editor with **The Journal**, has been awarded an honorary membership by the Ontario Medical Association (OMA).

She is only the second journalist to be so honored in the history of the OMA. Installation ceremonies were held as part of a joint OMA-Canadian Medical Association meeting in Ottawa in August.

Medical writer with *The Globe and Mail* for more than 25 years, Ms Hollobon is well known in medical and journalistic circles.

After her retirement from *The Globe* earlier this year, she joined **The Journal** staff in Toronto.

Hollobon

The Journal

Women in Nairobi

Backdrop for the future

Increasingly, abuse of alcohol and other drugs is causing concern in The Third World, as it continues to do in developed countries.

However, in the face of immediate and overwhelming problems such as poverty, drought, and starvation, little was said formally about addictions during the United Nations Decade for Women Conference, or the overlapping Non Governmental Organizations (NGO) Forum, held in Nairobi, Kenya this summer.

But, individual women — among more than 10,000 at the NGO Forum and 3,000 delegates to the UN Conference — spoke readily of their anxiety about the impact of alcohol and other drug use on youth and family life in their countries.

Contributing editor Joan Hollobon completes (The Journal, September) her coverage of the Nairobi meetings.

Women in Nairobi

NAIROBI, Kenya — Women at the United Nations Decade for Women conference were unanimous on one point.

Cheryl Mann from the University of Alaska's Center for Alcohol and Addiction Studies at Anchorage summed it up:

"The conference gave me the oppportunity to actually meet, talk to, and try to understand women from around the world on a one-to-one basis with no interference from government . . . to talk, person to person, about our families, our children, our work — what our lives are like. It was a real eye opener."

She made another point:

"We have to be really careful not to put our values on other people, and I think as North American women, we have a tendency to do that," she told **The Journal** after her return from Nairobi.

That includes the area of addictions.

Different philosophies

Thelma Williams, PhD, a professor of education at City University of New York, gave one example of the very different approaches to addiction. It emerged in a workshop she held at the Non Governmental Organizations (NGO) Forum on the Nairobi University campus.

"Different philosophies were very evident. Some felt alcoholism was an illness — 'I should not have been put in prison for what I did, because I was sick.' But, others said,'Are you saying a person should not be penalized for a crime if he is an alcoholic? Why shouldn't an alcoholic go to the same jails and be penalized like anyone else?' "

North Americans and Britons were more likely to hold the concept of alcoholism as an illness that diminishes responsibility for criminal offences, while people from The Third World in general took the much tougher approach of equal punishment for all, regardless of alcoholism or other drug addiction.

Dr Williams said she gained the impression that Third World people generally did not consider alcoholism an illness. In contrast, some United States women believed themselves victimized because they regarded alcoholism as something beyond their control for which they should not be blamed.

For example, she said, women representing Sisters of the Street, an Oregon organization, said their lives had been ruined by their being forced into prostitution when they were unable to get jobs and had nowhere to go because of their alcoholism.

Dr Williams, who specializes in early childhood education and child development, represented *L'Organization Mondiale pour L'Education Prescolaire*, a world body with headquarters in Strasbourg.

She told **The Journal** she became concerned about alcoholism and other addictions "because I have seen so many broken families, so many children who are addicted because of the addiction of their parents."

Toni D'Angelo, the International Council on Alcohol and Addictions' delegate to the NGO Forum, told **The Journal** the disposal of vast sums of money from international drug trafficking is a major economic influence in many Third World countries.

"The women I talked to did not seem to recognize this economic influence; they did not see the problem as a political issue."

Ms Mann was disappointed that a workshop on women and alcoholism proposed by the Alaska centre was turned down by the UN organizing committee in New York. She said the centre was told only two weeks before the conference opened that alcoholism would be looked at by a Canadian group doing "grassroots urban research in the Arctic." However, 'the Canadian group' was never identified and Ms Mann was unable to link up.

She suggested the organizers may have considered alcoholism and abuse of other drugs "more of a Westernized urban woman's problem, not relevant to the rural focus of the conference.

"We know from Alaska this isn't true, that rural women have just as many problems as urban women. I was very surprised at the lack of workshops on this subject," Ms Mann said.

Most discussions on drugs related to pharmaceutical products and centered around criticism of the "irresponsibility of US manufacturers in distributing drugs like DES (diethylstilbestrol) and Depo Provera (medroxyprogesterone)." (Distribution of these hormones in The Third World has been criticized on the grounds that they are not approved for contraceptive use in the US.)

The NGO conference was "so enormous, so overwhelming and, for the most part, quite well organized," Ms Mann said, but workshops would have been more accessible if they had been grouped in time and space on campus according to broad subject areas.

As it was, sessions on related subjects were often either held concurrently or were widely separated on campus, and sometimes turned out to be non-existent.

She did not attend Dr Williams' session, because she did not find it listed in the program, even though she was watching for addiction workshops.

Violence against women

The Alaska group ran seven other workshops on such subjects as women in management, women in prisons, violence against women.

Alcoholism and other addictions came up in many of these discussions, particularly in relation to violence, even though it was not the major focus of the sessions.

However, had the proposed workshops on women and alcohol been held, Ms Mann said she would have liked to share with women from other rural areas the knowledge gained in Alaska and learn of their experience in their own countries.

For instance, studies in Alaska have shown the different patterns in excessive drinking between urban and rural areas. Rural drinking in the North is frequently "situational" — excessive drinking occurs when alcohol is available, interspersed

After Nairobi: networking around the world

Postcard eloquence: from the Committee for the Disappeared, a demand to the UN Commission on Human Rights to free women prisoners in Iran

Tobacco problems

Tobacco was as strangely absent from women's discussions of actual and potential health hazards as alcohol at the UN's Decade for Women conferences.

Lung cancer associated with smoking is already overtaking breast cancer as the leading cause of cancer deaths among women in North America.

Only one anti-smoking poster by a group from Southeast Asia was observed among the thousands of posters glued on every available space at the University of Nairobi campus during the Non Governmental Organizations (NGO) Forum.

Lack of discussion was due primarily to the more immediate health problems facing Third World women — problems such as high maternal and infant mortality and communicable diseases.

Third World concerns received most attention at Nairobi — rightly, since they were more closely related to survival than those facing women in the developed world. The rise in lung cancer among Western women reflects increased smoking by women in the past 20 to 30 years. In women, as in men, the rising curves of lung cancer deaths closely match smoking patterns, but with a long latency period.

Women in The Third World generally do not smoke yet. But, it almost certainly will come. In India, for example, some young urban women working for multinational companies or in mass media, and who identify with their Western counterparts, have taken up smoking. In rural India, women smoke small indigenous cigars, and some rub powdered tobacco inside the cheek or lips. Oral cancer is frequently found among women who do this.

In Africa, a new target for the tobacco companies, smoking may increase among women as cultural patterns change.

These concerns were all expressed at the last World Conference on Smoking and Health held two years ago at Winnipeg.

A Nigerian physician at that meeting said cigarette smoking was already in-

Poverty hits home

At a NGO health workshop, a panelist described the hardships of elderly women pensioners in New York. Many in their 80s live on a pittance, cold and hungry in tenements. Poverty, homelessness, cold, and hunger are survival problems to the individual, even in developed nations. Yet, what were the thoughts of young African women in the audience? They were from poor countries where scores of children die in their first year and where women's average life expectancy is 50 years.

Contrasting points of view

Alongside a Peace Tent was a table with placards demanding lesbian rights. There, a young woman who said she had been a prostitute in Toronto talked nervously and with hostility to a male journalist. Immediately opposite, an Indian from Amnesty International offered a petition pleading for the life of a Nigerian woman condemned to death for drug trafficking. Further along, another petition announced another cause, "white women against racism and imperialism." It read: "The most immediate threat to world peace is United States and Western aggression and the nuclear and conventional arms race."

Pink pamphlets for peace

Surrounded by a display of all-too-familiar, horrible, but arresting photographs of death, mutilation, and destruction in Hiroshima, Japanese women handed out

Backdrop for the future

vith completely dry periods when it isn't.

Women alcoholics also are not identified s often as men in rural areas, because there's still so much stigma about women rinking," with resultant problems in proiding suitable treatment programs and ollow-up care.

The stigma for women in many develping countries is even greater.

Ms Mann said every opportunity should e taken to discuss alcoholism among vomen, particularly at international conerences, because "awareness and education and the freedom to discuss it will be a actor for change. Think where we were 20 years ago — alcoholism was not freely discussed. It's just a matter of being at a different point on the continuum."

healthy future

In Alaska, abuse of other drugs is rising, with cocaine probably at the top of the list now. Cocaine abuse is becoming a major problem among the Native population. An Alaskan senator recently held hearings on drug abuse in rural populations, she said. Possession of up to four ounces of marijuana for personal use is legal in Alaska, although not for adolescents, for whom it is the drug of choice. The drinking age is 21 years.

Ms Mann, a social worker who has worked on substance abuse since 1971, is an assistant training coordinator at the Anchorage Center, University of Alaska's School of Health Sciences. It is a research, teaching, and training centre for people entering the health sciences or those already working in the counselling field, and holds a school of addiction studies for some 500 participants every summer.

Lack of concern

At Dr Williams' workshop at the Forum were faculty members and students of the University of Nairobi medical school, as well as teachers, nurses, and parents. The largest contingent came from Kenya, she said, but there were also many delegates from other African countries, Britain, Europe, and the US. Among them were several alcoholics.

"Some of these people recounted their personal experiences. It was quite moving to hear them testify to the hardships they had suffered. They were upset at the lack of concern and the lack of knowledge around them and they wanted to warn others," she said.

Dr Williams, who also does family counselling and psychotherapy, has considerable sympathy for the African women who spoke approvingly of severe punishment for drug traffickers. (Several African women said they approved of the Nigerian government's intention to execute a woman convicted of trafficking.)

After seeing the havoc wrought in New York city by drug traffickers, who invade the schools, hospitals, and jails, Dr Williams said she can understand this attitude.

A young Canadian, who hopes to work as a physician among the Native people of the Canadian Arctic, found the NGO conference an opportunity to meet the indigenous women of the US and Australia.

Debrah Bray of Montreal is a pre-med student at Concordia University. She hopes to enter McMaster University medical school.

Her interest in attending the Nairobi conference arose from her experiences in Inuvik, the Northwest Territories, where she spent eight months in 1983 to 1984.

Having been a telephone counsellor for about four years at suicide distress centres, she was particularly concerned about the high suicide rate among young people. "I found I was able to get quite close to them because I wasn't much older than they were," she said.

She found alcohol was a factor in 65% of the suicides in the North. Gasoline sniffing and abuse of many different substances, including phencyclidine, was also widespread. Traffickers selling drugs to the oil riggers peddled poor-quality drugs, mainly marijuana, to young Native people, including children, she said.

Alcoholism and other forms of addiction came up in the course of workshops or even conversations with indigenous women from other countries, Ms Bray said.

Janet McCloud/Yet-Si-Blue, a Tulalip Indian from Washington state, and a member of the Grassroots Leadership Delegation to the NGO Forum, told a workshop that three of her 12 children had become alcoholics.

Ms Bray said problems of the homeless in the harsh climate of northern Canada paralleled situations Ms McCloud described, where the homeless seek refuge from the cold in bars and refuge from hopelessness in the alcohol the bars provide.

Year of the Homeless

She said that during the 1987 Year of the Homeless, the importance of shelter on other problems such as alcoholism should be recognized.

Ms Bray met a young Australian aborigine woman who described problems there — the stereotyping of Native people, alcoholism, and suicide — that also were similar to those in Canada, "even though we came from opposite sides of the world."

Ms Bray was disappointed, however, that the NGO Forum did not provide more opportunity for young women to express their views and concerns. She said she found nothing on suicide among youth. (*Forum '85*, the NGO Forum's daily newspaper, reported one youth plenary session. The report noted that during the final question period "older women in the audience refused to sit down to allow the young women to express their views.")

All three women reflected a feeling among many at Nairobi — personal contacts and new ideas more than compensated for frustrations.

Said Cheryl Mann: "I was impressed by how hard women tried to communicate, how they tried their best not to allow politics and that kind of thing to interfere with really listening to one another . . . . I have made personal contacts with people whom I shall probably stay in touch with most of my life."

drift to Third World

reasing so much among young men there hat he feared the foundation was already aid for lung cancer deaths within a few ears.

Anthony B. Miller, MD, of Canada's Naional Cancer Institute, told the 4th World Conference on Lung Cancer in Toronto in August: "The problem of smoking has overshadowed this meeting and in many respects has been its conscience."

James Cullen, MD, of the United States National Cancer Institute, said smoking and lung cancer among men is levelling off n the developed world, but in developing countries there is an increase in production and in consumption — "That's where he cigarette is beginning to go."

Also, tar and nicotine levels are generaly higher in cigarettes in The Third World. People there are less aware of the hazards, and many countries do not yet require hazard labelling.

Passive smoking is also receiving more attention. Japanese research has documented rising cancer rates among the wives of heavy smokers. The Japanese investigators suggest the passive smoking effect may be particularly pronounced where household members live in close proximity, as is the custom in Japan.

Since similar housing customs exist in many Third World countries, women there are likely to face similar hazards as smoking increases among the men.

Both speakers at the Toronto conference noted that the current rate of one million lung cancer deaths a year around the world is predicted to rise to two million a year by the year 2000.

Dr Miller also remarked on the falling smoking rates and levelling cancer rates among men in North America, Britain, and Australia.

"The challenge is to extend this gain to women, and even more so, by legislation, example, and education to countries of The Third World," Dr Miller said.

Women in progress: raising consciousness in Kenya

Tomorrow: staying in touch for life

pink pamphlets bearing a poem and a tiny green origami bird: "Give me back my father. Give me back my mother. Give me back old people. Give me back our children. Give me back Me . . . Give me back Peace — Peace that will not fail as long as this lasts, this life."

Women's awareness

Maendeleo Ya Wanawake Organization (MYWO) is Kenya's leading women's organization. Begun in 1952, its aim is to provide leadership and training, to raise women's awareness of their important role, and to develop and improve their status and conditions of life. MYWO (it means women in progress) put on a "live" workshop, setting up a typical village market in open space opposite the University of Nairobi. Open-fronted huts displayed crafts, baskets, leather work, household goods, food, etc. Nearby was a fruit market doing brisk business among NGO delegates. The rural scene provided a sharp contrast to the opulent-looking Mount Kenya Safari Club close by on University Way.

Mothers gain respect

Sons in predominantly Moslem Malaysia are developing new and more respectful attitudes to their mothers, in villages where a program of cottage industries has been started. Children "no longer expect her to be like a servant," said Khairiah Khairuddin. The boys see their mothers at work at jobs — book-binding, carpet-weaving, mushroom-farming, pottery, or making things.

Women in Nairobi
Backdrop for the future

Women's groups fight pharmaceutical multi-nationals

Health concerns voiced at the NGO Forum

The absence of controls on the sale of prescription drugs in developing countries concerned many delegates to the NGO Forum.

Pharmaceutical products exported to The Third World should be subject to the same controls that operate in their country of origin, declared the International Network on Women and Pharmaceuticals-Health Action International (WEMOS-HAI).

WEMOS wants to see the World Health Organization adopt an international marketing code for pharmaceutical companies to make it impossible to export drugs that cannot be marketed in their home country.

WEMOS, a small but forceful organization in The Netherlands, has battled successfully the mammoth Dutch multi-national pharmaceutical firm, Organon, over marketing anabolic steroids as growth agents for children. It is gearing up now for similar battles on the selling of high dose estrogen-progesterone (EP) drugs in The Third World.

WEMOS' weapons are the law, publicity, and lobbying politicians.

WEMOS also scrutinizes Dutch policy on Third World issues, particularly how The Netherlands spends its money in developing countries. It has a particular interest in the health of Third World women.

Marlein van Rooy of Amsterdam told **The Journal** WEMOS receives some support from the Dutch government, but relies mostly on some 150 volunteers, mainly physicians and pharmacists.

D.E.S. Action was another group at NGO Forum 85 concerned about pharmaceutical products its members consider hazardous, especially to women in Third World countries lacking regulatory controls.

"D.E.S. — the wonder drug you should wonder about" read a poster displayed by Harriet Simand of Quebec City and Ellen t'Hoen and Anita Direcks of Utrecht.

D.E.S. Action says DES (diethylstilbestrol, a synthetic estrogen) has been prescribed to prevent miscarriage "to millions of pregnant women throughout the world since 1941, under many brand names and in the forms of pills, shots, and suppositories."

WEMOS and D.E.S. Action both claim DES is still being prescribed in many parts of the world, despite evidence in 1971 that some girls born to mothers given DES developed vaginal cancer in young adulthood.

Subsequently, researchers found that sons also could suffer from problems of the reproductive organs and that the mothers themselves had a higher-than-average risk of developing breast cancer later in life.

D.E.S. Action publicizes the problems so that people at risk can seek medical surveillance and early treatment if required.

Harriet Simand said DES is also being prescribed in The Third World to induce ovulation, to suppress lactation, and as a "morning after" contraceptive. In Latin America, DES residues in meat from animals fed the hormone to increase growth rates have been blamed for causing precocious puberty in girls as young as two years old, she said.

So far, D.E.S. Action has chapters in the United States, Canada, and The Netherlands, but the trio at the NGO Forum hope for an international network of chapters. They distributed pamphlets in English, French, Dutch, German, Spanish, Swahili, and Arabic.

Ms van Rooy, one of two full-time, paid WEMOS employees, said two years ago WEMOS took its information on the sale of anabolic steroids to the Dutch pharmaceutical industry's commission on ethics.

She said anabolic steroids were being marketed in developing countries without prescription and with a leaflet saying they were good for undernourished children. An advertisement for the hormone had a picture of a giraffe for a child to be measured against as it grew.

Ms van Rooy said public interest and criticism by the industry's own commission led to revision of the leaflets to include the same information as the product monograph.

"But, we have proof that in Costa Rica, Pakistan, and Nepal, the drugs are still selling as before. In India, they changed the leaflet a bit, but the drugs are still being marketed aggressively over-the-counter," she said.

The pharmaceutical industry claims it needs such sales to provide funds for research, but the research is on the diseases of the West, not tropical diseases. "Poor people in The Third World are squeezed out by research for rich people's diseases," she said.

WEMOS also is concerned about contraceptive products, including the injectable hormone progestational agent Depo-Provera (medroxyprogestrone acetate).

Women in developing countries should have "free, informed choice," based on correct information about contraceptives and should not be forced into family planning programs. Ms van Rooy said she is against the double standard that allows for test- tube babies for infertile couples in the West but forces Third World women "to find the solution (to overpopulation) through their own bodies."

If Depo-Provera is not considered safe enough for contraceptive use in the US, it is not safe enough for use in developing countries.

DES and EP drugs should be banned at once, but WEMOS is asking for more discussion of Depo-Provera rather than an immediate ban because, she said, it recognizes that constant pregnancy, which is the experience of many women in developing countries, poses a greater health hazard than the drug.

(Africa has the highest fertility rate in the world, at 6.4 children per woman, compared with an average 3.8 for the rest of the world. The average life expectancy of Africa's estimated 237 million women is 50 years, compared with 76 years in the developed world.)

The aim of WEMOS is to establish an international network on the subject of pharmaceuticals, so informed women in each country can put pressure on their own governments to establish proper safeguards. Concern about possibly unsafe birth control methods, however, does not equate with opposition to family planning.

A statement signed by more than 100 NGO delegates from 45 countries was submitted to Maureen Reagan, leader of the US delegation to the UN conference, protesting the attempt by pro-life groups to persuade the US to cut off support for family planning programs in The Third World.

The statement charged that the "so-called 'pro-life' lobby at the conference has been trying to ride on the backs of Third World women by using the fact that we criticized unsafe family planning methods."

Health was in the forefront of the women's minds at the NGO Forum: every workshop on health was jammed. Many were on primary health care, bearing out a statement in the UN report.

Noting the benefits in training local women as health workers (for example, a drop in deaths from neonatal tetanus in India, to 10 from 90 per 100,000 through such a program), the report says women's involvement stops at higher levels among doctors, health ministry officials, and hospital administrators. Women are "grossly under-represented" at these levels where policy is set and funds allocated.

"And, that money tends to stay just where it is. Three-quarters of the world's health problems could be solved by primary health care. But, three-quarters of developing countries' health budgets are spent on doctors and hospitals," the report said.

You should wonder: using publicity to try to help Third World women at risk are (l to r) Anita Direcks, Ellen t'Hoen, Harriet Simand

ESSAY

Demand, economic growth now supercede health

Alcohol policy - a maze of conflicting interests

Alcohol control is an area of public policy characterized by dilemma and conflict. While the health and social damage resulting from alcohol use are well recognized and documented, equally well recognized are the benefits of alcohol use. Alcohol is a product associated with relaxation and conviviality and is also a valued source of economic benefit to Canadians.

This is the view of R. A. (Ron) Draper, director-general, health protection branch, Health and Welfare Canada. He says the story of how governments pick their way through this maze of conflicting values and interests is the story of alcohol control policy in Canada.

In a speech to the 34th International Congress on Alcoholism and Drug Dependence in Calgary in August, Mr Draper described trends in alcohol control policy in Canada for the past 40 years, discussed influential factors at play, and suggested prospects for the future.

Following is the text of Mr Draper's presentation, condensed for ***The Journal.***

It is important to situate Canada with respect to alcohol as a public health issue. Canadians, as is often the case, stand squarely in the middle. In terms of per capita consumption in 1980, Canada stood 16th among 35 countries reporting in an international comparison, with an annual consumption of 9.1 litres per inhabitant. Rates of consumption, after rising 25% between 1970 and 1975, have levelled off. Although alcohol problems are serious, they are not viewed as being extreme except in certain localities or situations.

Canadian response to alcohol as a public health problem is also middle-of-the-road. While we have alcohol control policies in place, they are not restrictive. As a counter-balance, a good deal of work in the past 15 years has been devoted to developing an infrastructure for specialized alcoholism treatment and for primary prevention using information, education, and some community organization. (Most treatment and prevention programs operate under the direction of commissions or foundations directed and funded by provinces.)

It is important to understand the infrastructure within which control occurs. Thirteen governments are involved — 10 provinces, two territories, and the federal government. Provinces and territories set the price for alcohol, regulate the conditions under which it is advertised and sold, and, in most cases, are the major vendors under monopolistic arrangements.

The federal government is involved in other ways — by levying taxes and duties on alcohol and by regulating advertising of beer and wine on radio and television, an area of jurisdiction it shares with provinces. It also establishes penalties for impaired driving under the provisions of the criminal code.

Because of the number of jurisdictions involved, a precise account of Canadian alcohol control policies would be encyclopedic and too complex to express meaning. Following, then, are generalizations, any one of which could be challenged validly or qualified with respect to specific provinces.

Religious fervor

Historically, Canada's approach to alcohol control was highly restrictive. In the early part of this century, the temperance movement was a powerful force. In its heyday, it enjoyed support from most Canadians, combining social concern with religious fervor. Not surprisingly, the result was a public policy of prohibition.

Prohibition was followed by a period of highly-restrictive controls, which lasted until about the end of World War II. Alcohol was highly priced, and barriers, such as permit systems and limitations on the numbers of outlets, were used to restrict ease of purchase. Most provinces did not permit consumption of spirits in public places, including restaurants. Sale of beer was restricted to "beer parlors" — dingy, unattractive, and segregated into male and female sections. The combined temptations of booze and sex were deemed too strong a mix for Canadians.

World War II was a time of social upheaval. Men went to war, and those who came back returned with a new, more cosmopolitan view of the world. Women went to work and came home with a different sense of what it meant to function independently in society. It is not suprising that at the end of the war came the political conclusion that the time had come to adopt alcohol controls which reflected a more liberal expression of the public will.

Political motives

Structurally, the movement away from prohibition was reflected in provincial establishment of systems vesting the power to control price and availability of alcohol in somewhat autonomous liquor control boards or commissions. The policies adopted involved price and taxation of beverages. A minimum age requirement for purchase of alcohol, definition of the types of licensed alcohol outlets, stipulation of the hours during which outlets could be open, and restrictions on advertising.

As alcohol controls stood during the last half of the 1940s, one can see a delicate balance of political motives, all of them legitimate — including response to new public expectations, a desire to protect public health and morality, and a wish to secure an appreciable, reliable source of government revenue.

The four decades following 1945 paint a picture of incremental but consistent movement toward less restrictive controls. Some moves were deliberate; others look inadvertent. All of the original policy goals remain part of the debate, but public demand and economic growth or stability now far exceed public health as the prominent factors in decision-making. Thus, alcohol control has become less a matter of social policy and more a matter of economic policy.

Draper

'Understanding change is the beginning of policy wisdom. If relaxation of controls has damaged Canada's health, what forces led to this change?"

The relaxation of restrictions reflects changing social reality since 1945. Canadian society has become increasingly open and pluralistic. Already bi-cultural, it has sustained several decades of high immigration. Incomes have risen, leaving more money for discretionary spending on food and beverage. Canadians travel widely and bring home a lively appreciation of the eating and drinking customs they find in other parts of the world. All of these trends interact to make alcohol an integral part of this country's social life.

In specific terms, the changes in controls that have occurred are:

• **Availability** — Alcohol has become incrementally more accessible, particularly since the 1960s.

Hours of sale in bars, taverns, and restaurants now extend from before noon until well after midnight. Virtually any establishment that serves food can be licensed to serve alcohol. Securing a licence for public premises has moved from being a privilege to being a right. Self-serve stores provide the purchaser with easy, attractive access to an unlimited variety of wines and spirits. Travellers may drink in airports and stations, on planes and trains, and at summer resorts. Students use campus pubs. Special event permits are available for fairs and festivals. In some provinces, beer is sold in sports stadiums. In Quebec and British Columbia, government monopoly has been weakened through sale of wine and beer in corner groceries.

The cumulative effect is the virtual elimination of restrictions on access as an element in control.

• **Age of purchase** — A significant factor in control is the minimum legal age for buying alcohol. Historically, the minimum age was 21 years. Then, between July, 1970 and July, 1972, all jurisdictions reduced their age limits to 18 or 19 years.

The consequence of age reductions was more problematic drinking by young people, manifesting itself in an alarming increase in automobile accidents among the 18- to 20-year age group. Also disturbing was the "trickle-down effect," where 18 year olds use their access to buy alcohol for younger friends. Two provinces — Ontario and Saskatchewan — have raised their age limits back to 19 years, but there has not been a move back to 21 years.

• **Price** — Final alcohol prices are set by the provinces and include provincial sales taxes and price mark-ups. Also included are excise taxes, import duties, and sales taxes levied by the federal government. Thus, both levels of government gain revenue benefits. In 1982-83, provincial revenues exceeded $2 billion; the federal government collected $1 billion. Taxes on spirits, beer, and wine respectively amounted to 72%, 45%, and 54% of average consumer prices.

Canada maintains a fixed-price system consistent with prevalent monopolistic arrangements. That is, retail price competition does not occur. However, the trend in the relative price of alcohol has been down, and drinking is a much less substantial drain on the consumer pocketbook than it was 30 years ago.

• **Marketing** — Historically, our systems of tight control and monopolistic distribution offered a stable framework for efficient production and selling of alcohol. In a strange sense, they helped producers by reducing uncertainty in the marketplace.

So long as total consumption grew — even slightly — everyone (except, perhaps, those concerned with public health) seemed relatively happy. However, when markets flatten or decline as they have recently, the level of general happiness in the marketplace drops correspondingly. The result, especially for beer, has been an intensely competitive scramble to retain or get larger shares of the present market or find new ones. New, young drinkers and women are seen as the best potential markets. Aggressive selling with comprehensive marketing strategies is a new phenomenon which Canadian alcohol control policy has not yet confronted.

Virtually all brewing in Canada is done by three large corporations. Each sells several brands of beer of both regular and light strength, as well as well-known labels from other countries. New packaging and new brands are the order of the day, creating instability in a flat market. Advertising, ownership, and sponsorship are key strategies in beer marketing.

Advertising controls have a long history in Canada but are now weak. There are few outright prohibitions. Spirits cannot be advertised on radio or TV and two small provinces have blanket prohibitions. Policy is one of control rather than prohibition; advertising, then, is allowed, but with restrictions on size, location, frequency, and content. These controls, particularly on content, are subject to constant interpretation and re-interpretation moving consistently in the direction of relaxation. The history of advertising controls, almost without exception, shows that when control authorities compete against the creative genius of advertising agencies, they are fairly consistent losers. Canadian experience confirms this. There are no policies or structures through which public health perspectives get reflected in decisions about advertising.

Identity and goodwill

In recent years, brewers have moved into the ownership of professional sports teams, especially hockey, baseball, and football. There are no controls; brewers gain the identity and goodwill that go with being visibly associated with teams of national prominence, as well as the exclusive right to televise home games, thus keeping their products visible to potential customers.

Few controls have been placed on sponsorship. As a result, brewers fund a multitude of amateur and other sporting events targeted to young people. As one commentator put it: "The brewers will support anything that moves, or rather anything a beer drinker would like to watch move." A disturbing trend of more recent origin is the move into brewery sponsorship of rock video shows that have youth as their primary audience. Analysis shows that of 35 shows in Canadian markets, virtually all were sponsored by breweries. For about two-thirds of these, children and youth under 18 years made up at least 50% of the audience.

Canada has come a long way in 40 years. Limits on availability have been virtually eliminated, relative price has dropped significantly, and aggressive product marketing is allowed. Whatever the intent and impact, policy direction clearly has changed.

Understanding change is the beginning of policy wisdom. If relaxation of controls has damaged Canada's health, what forces led to this change? What are the reasons and rationales used to explain and justify these trends? Two factors stand out — public acceptance and economic benefit.

Few Canadians, I think, wish to have beer sold aggressively to the young. But, it is fair to say that they accept it. For most Canadians, alcohol presents no problem. While they accept counter-advertising or prevention and humane alcoholism treatment, they do not view their own inconvenience as essential for the protection of others.

Alcohol is seen as a problem for individuals, not for the general society. Perhaps this is all part of a general, continental drive away from the historic concept of the public good and toward increasingly narcissistic notions of individualism.

Big business

The second contributing factor is a strong coalition of economic interests. It may seem provocative to resurrect the debate of health vs wealth, but the inference seems unavoidable. Alcohol is big business. Sales generate $7 billion annually in the Canadian economy, of which $3 billion find their way into government coffers, accounting for more than 2% of total revenue. Twenty thousand people work directly in alcohol production and related industries. Agricultural sales for grain and grapes amount to $140 million each year, and $150 million or more probably are spent for media purchase. In a decade of high unemployment and rising deficits, these numbers speak with considerable political force.

What does the current state of control policy imply for the future? Available evidence offers no grounds for predicting a return to the restrictive system of controls that applied 40 years ago. While there are pockets of vocal concern about particular groups or problems, proposals for comprehensive change do not figure significantly in public discourse.

If return to comprehensive, restrictive controls is unlikely, what policy options remain for a country committed to prescrv-

(continued on page 8)

ESSAY AND NEWS

Control needs balance of persuasion, regulation

(continued from page 7)

ing its health? Obviously, there are only two — prevention through means of persuasion, and humane treatment of drinking consequences.

Prevention based on information, education, and community organization has fallen into some disfavor because of perceived lack of significant benefit. Control measures are recognized as having more direct, immediate impact. But, if there are constraints on acceptability of controls, then the cumulative, long-term effect of pervasive strategies will have to be revisited and thought about more carefully.

Perhaps the levelling off of Canadian consumption trends means a new ethic is abroad in the land. This trend may reflect age distribution in the population, pressure on personal income, or that Canadians, because of health campaigns, are internalizing their own alcohol controls.

I do not want to suggest, however, that the possibility of gaining more from persuasive strategies suggests we can rely on them exclusively. Such a scenario ignores the action/reaction pattern into which we are moving.

Tobacco and alcohol experience are beginning to demonstrate that as demand falls in response to changing public norms, entrepreneurs respond with more pervasive and frenetic marketing activity. When this happens, personal choice does not occur in a neutral environment, but rather in a hostile environment, rich with images supporting use of tobacco and alcohol. The marketplace, in effect, competes against the efforts of the state to preserve public health.

Canada supported the World Health Organization resolution calling for national alcohol policy based on control of availability and reduction of demand. This implies twin strategies — one using regulations, and the other based on persuasion. Perhaps, a better future will lie in an integration of the two.

What we seem to need is not just campaigns addressed to individual behavior, but more broadly-based public discourse on the role of alcohol in our society, the way we want to use it, and the way we are willing to have it sold. Perhaps through this route, we can strike a balance between public health and public preference.

Implementation is voluntary

Manitoba hospitals boosting non-smoking rules

WINNIPEG — More Manitoba hospitals are voluntarily implementing non-smoking policies, a survey by the Manitoba Lung Association shows.

The survey of 34 hospitals here and in western Manitoba found all but one had introduced some policy restricting smoking.

Since the study earlier this year, the holdout — Roblin District Health Centre — has also brought in a non-smoking policy. Clint Clearwater, executive director of the hospital and nursing home, told **The Journal**: "I think you're going to see everyone go this route."

Of the 34 hospitals surveyed, only eight prohibited smoking anywhere in the building, said Susan Hayward, coordinator of the western region of the lung association. All of the others limited visitor and staff smoking to designated areas, she said.

Policies varied from hospital to hospital on the issue of allowing smoking in patient rooms, with some places allowing patients to smoke in bed only if attended by staff and others permitting the practice only "under extenuating circumstances," she said.

A resolution calling for non-smoking policies in hospitals was passed by the Canadian Hospital Association (CHA) nine years ago and reaffirmed last year, Roseline MacGillivray of the CHA in Ottawa, said.

But, she said, that resolution, which recommends hospitals also suspend the sale and use of tobacco products, has never been forced on anyone.

"It's the prerogative of each hospital to administer it as it sees fit."

James Murray, MD, of the Canadian Council on Hospital Accreditation, said his council has not made non-smoking policies a requirement for accreditation. "We certainly have several regulations regarding smoking — such as in rooms where oxygen is used — but these are mainly for fire and safety reasons."

Dr Murray said the council is considering implementing a standard of non-smoking policies for hospitals for public health reasons and to set a good example. "It's a topic whose time has come.

"Until recently, it's been very difficult even to get hospitals to stop selling cigarettes in their shops and snack bars," he said, adding he hopes new standards will be introduced soon.

Margaret Thomson of the Manitoba Interagency Council on Smoking and Health, told **The Journal**: "I think in health facilities, they should be expected to have a policy."

Ms Thomson admitted it may be difficult to outlaw smoking altogether in some facilities, especially when smoking patients may be there for extended periods of time.

While there could be smoking areas set up in hospital cafeterias, she said, "I don't think patients should ever be allowed to smoke in their rooms. . . . I'm disappointed that (hospital) wards have not gone further to resist smoking in patient wards."

Prince Edward Island honors Killorn

CHARLOTTETOWN, PEI — Leo Killorn, director of Queen's County Addiction Services here, has been conferred with an honorary Doctor of Laws degree from the University of Prince Edward Island.

Dr Killorn, MD, received the degree in recognition of his work in the rehabilitation of alcoholics and other drug dependents.

In 1979, Dr Killorn was named Islander of the Year by the *Evening Patriot* newspaper. In the same year, he was also presented with the David H. Matheson Memorial Award for his work in the criminal justice system.

Dr Killorn was the executive director of the PEI Addiction Foundation in 1973. Since that time, he has operated Addiction Services, a private clinic for the treatment of alcoholism and other drug dependencies.

MD: most alcoholics still slip by diagnosis

WINNIPEG — Doctors fail to diagnose about 80% of alcoholics because medical schools offer little preparation to cope with the disease, says a Winnipeg addictions specialist.

William Jacyk, MD, a professor of medicine at the University of Manitoba (U of M), and a medical consultant to the Alcoholism Foundation of Manitoba (AFM), says doctors are not taught how to detect alcoholism; they often rely on the image of an alcoholic they have in their minds.

"If he looks like that, then we spot him. But, if he doesn't fit our stereotype, then we miss him," he said. "It kind of tells you right from the beginning that we're starting out behind the eight-ball," Dr Jacyk told doctors during a symposium on alcohol and drug abuse at the U of M.

Dr Jacyk said only about 10% of those admitted to the AFM's treatment program during the last six months of 1984 were referred by doctors or hospitals.

He said doctors should be aware of early symptoms of alcoholism and "should develop a sensitive set of antennae" to detect the problem.

Many times those with problems will deny them, Dr Jacyk said, warning doctors not to be pulled in or manipulated by such people. "We may have a tendency to overlook or ignore them and miss their chemical dependency. We may even contribute to it by prescribing for them," he said.

Frederick Glaser, MD, head of psychiatry at the Addiction Research Foundation in Ontario, said studies show almost one-quarter of patients in hospitals have alcohol problems, but many times they go unnoticed amid physical ailments. "It's there, but it's not being recognized."

Dr Glaser, who also teaches psychiatry at the University of Toronto, said alcoholism, contrary to some beliefs, is not always a symptom of a psychiatric problem. Some alcoholics and other chemically-dependent people may have such problems, but the two are separate diseases.

"The depression we commonly see with those with alcoholism and drug abuse problems is the result of the drugs themselves," he said. "Even when they co-exist, they are two independent conditions and they should be treated like this."

AA convention report

Detox centres are first step

MONTREAL — Patients who check themselves into expensive detoxification centres may not be getting their money's worth, says Jerry Shulman, a vice-president with Addiction Recovery Corporation, Waltham, Massachusetts.

"Treatment centres where people pay high fees owe the patient more care than they would get by going to AA (Alcoholics Anonymous) meetings," Mr Shulman told the AA 50th anniversary meeting here.

The role of treatment centres is not to cure patients of the disease of alcoholism, but to prepare them for long-term care, he said.

Mr Shulman defined the role of a treatment centre as:

- to get the patient to accept that he has a problem;
- to begin motivation for change; and,
- to get the patient to make a commitment to join and keep going to AA.

Treatment facilities are only a first step on the long road to recovery.

Reviewing his own 25 years working in the field of alcoholism, Mr Shulman said when he started the main requirements for someone who sought work in the field were sobriety and a "willingness to work cheap.

"What we had in the 50s and 60s were rehabilitation centres and intervening care facilities, which were really 'drunk farms.' "

In the mid-60s, professionals with academic degrees emerged — social workers, psychologists, physicians. "They became aware of a need and saw they had a place in the care of alcoholics. It became acceptable to treat such patients. Suddenly, you didn't have to work at poverty level to be employed in the business," Mr Shulman said.

However, from the first there has been marked inequality between university-trained staff members and AA counsellors — in terms of pay, working conditions, prestige, and promotion.

Diane Hobbs, head of hospital outreach service, Clinical Institute, Addiction Research Foundation of Ontario, said she came into the alcoholic field without ever having tasted alcohol. Her most vivid recollection as a student nurse was of a patient, a woman under age 40, who was told by her doctor she must stop drinking or die. Ms Hobbs: "The doctor had prescribed. It was her responsibility all by herself to obey." Obviously, the doctor had no comprehension of what life without drinking would mean to her, she said.

Since then, Ms Hobbs has learned that while there is life, there is hope. "When hope fails, I have a whole computer printout in my head listing the names of those who have demonstrated the miracle of recovery."

Ontario now has 17 detox centres, she said, and the ministry of health has approved funding for five additional services for women.

A program that began as an alternative to the drunk tank is now viewed in the province as a "preferred site for providing support to intoxicated people needing assistance in the sobering-up process.

"It does not replace hospital, nor does it always replace jail. Some would say we have developed our own revolving door."

Ms Hobbs said Ontario has some treatment centres whose philosophy is based exclusively on AA.

"The greatest thing AA has given centres is the message of hope, that recovery is possible."

Ms Hobbs urged AA members to be patient with young professionals just entering the field.

It is important, she said, that staff, AA and non-AA, learn to respect each other.

DEPARTMENTS

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Growing up Stoned

Number: 665.
Subject heading: Drugs and youth; youth and alcohol.
Details: 52 min, color.
Synopsis: The effects of drug use on three young people are illustrated. Adam, 17, has been using marijuana for four years. He can no longer concentrate on his school work; his relationship with his father has deteriorated to the point where he is kicked out of the house; his ambition of being a musician seems now lost. John, 16, has been expelled from grade nine for fighting and truancy. He smokes marijuana, drinks heavily, and no longer participates in sports, but hangs around with other drug users. The problems his parents face in trying to help him are shown; even after being charged with the theft of their car, he still maintains he prefers drugs to being straight. Heather, an exceptionally gifted and successful 16 year old, lives with her separated, recovering-alcoholic mother, who, after 12 years, still has serious conflicts with her former husband. Heather has been getting stoned for years, and drinks heavily. She has a drunk-driving accident, enters an adolescent drug treatment centre, and remains sober for six months.
General evaluation: Good to very good (4.6). This contemporary, well-produced film was judged useful for provoking discussion about youth and drugs. Public broadcast was recommended.
Recommended use: With a resource person, this film could benefit audiences 15 years and older, especially parents.

Medical Effects of Alcohol Use

Number: 666.
Subject heading: Alcohol pharmacology.
Details: 25 min, color.
Synopsis: Animation illustrates the path of alcohol throughout the body, the process of metabolism, and the effects on body systems. A party scene is used lightheartedly to demonstrate the different effects of alcohol: a man experiences depression, impaired coordination, rejection of his advances to a woman, and, the next morning, both a hangover and an angry wife.
General evaluation: Good (4.1). This contemporary, well-produced film was judged a good teaching aid. Public broadcast was recommended.
Recommended use: With a resource person this film could benefit audiences 15 years and older.

Medicine, Drugs and You

Number: 667.
Subject heading: Drugs; pharmacology; drugs and children.
Details: 12 min, color.
Synopsis: Medicines (drugs) can be useful when one is sick, but they should be used carefully and only with adult supervision. Some drugs look like candy, therefore, children are advised never to take anything from a stranger. Correct storage of drugs is stressed. Alcohol, tobacco, and caffeine are also briefly discussed: as drugs, they must be treated with caution.
General evaluation: Good (4.2). This film was judged a good teaching aid. General broadcast was recommended.
Recommended use: With a resource person, this film could benefit children eight to 11 years old.

Drugs Abuse Test

Number: 670.
Subject heading: Drugs and youth.
Details: 25 min, color.
Synopsis: Statistics indicate alcohol and other drugs play a great part in our everyday life. More young people in the United States drink now than at any other time in history. Through interviews with professionals, the physical and psychological effects of drugs are given. A series of questions is presented and then answered by professionals. Teenagers relate their experiences with drugs. The film advocates drug education as the solution to drug abuse.
General evaluation: Poor to fair (2.6). Although recent, this film was not judged a good teaching aid because of potential emotional reactions to statements such as marijuana is a "profound biological poison."
Recommended use: None.

The Last Prom

Number: 672.
Subject heading: Impaired driving.
Details: 24 min, 16 mm only, color.
Synopsis: Two couples are going to the high school prom. The boys start drinking covertly at the dance. The two couples go for a ride in one of the boy's vans and continue to drink. They crash into a bridge abutment, killing two people and injuring another. Later, we see the principal talking to grief-stricken students. Then, we see the funeral.
General evaluation: Good (4.1). This contemporary, well-produced film would facilitate discussion about drunk-driving. General broadcast was recommended.
Recommended use: With a resource person, this film could benefit those 15 years old and over. It is especially appropriate for driver-education courses.

Everybody Wins

Number: 669.
Subject heading: Employee assistance programs(EAPs).
Details: 35 min, color.
Synopsis: In this lecture, EAPs are outlined from a manager's point of view. It is frustrating to have employees with poor work performances: lateness, absenteeism, and substandard work. Through EAPs, employees get the help they need and managers regain productive staff members. The procedures to achieve this outcome are outlined.
General evaluation: Poor (2.2). This lecture-format film was judged to be boring; general statements were made that would be difficult to apply to most situations.
Recommended use: This film was not recommended for any audience.

Books

The Addictions: Multidisciplinary Perspectives and Treatments — Milkman, Harvey B. and Shaffer, Howard J. (eds). D.C. Heath, Toronto, 1985. Inheriting addictions; biological mechanisms; trends in behavioral psychology; interaction of personality and social setting; the justice system; treatment perspectives. 204p. D.C. Heath Canada, Suite 1600, 100 Adelaide Street West, Toronto, Ontario M5H 1S9. $33.95. ISBN 0-669-08739-4.

Directory of Alcohol and Drug Treatment Resources in Ontario 1985 — Catherine Blake (ed). Addiction Research Foundation, Toronto, 1985. Program descriptions; special indexes for treatment type, services for special populations, special focus. 450p. Addiction Research Foundation, Marketing Services, Dept JR, 33 Russell Street, Toronto, Ontario M5S 2S1. $16. ISBN 0-88868-102-X.

Alliance for Change — Crowley, James F. Community Intervention, Inc, Minneapolis, 1984. A plan for community action on adolescent drug abuse; general strategies for community mobilization; barriers to action; focus on school drug problems; school program dynamics; individual efforts. 223p. Community Intervention, Inc, 529 South 7th Street, Suite 570, Minneapolis, MN 55415. ISBN 0-9613416.

Community Response to Alcohol-Related Problems: Review of an International Study — Ritson, E.B. World Health Organization, Geneva, 1985. Background and organization of the study; drinking practices, alcohol-related problems, patterns of community response in the participating countries including Mexico, Scotland, Zambia; reflection on the outcome of the study and the implications for future action. 58p. World Health Organization, Geneva, Switzerland. ISBN 92-4-130081-7.

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

What an Employer Needs to Know to Make an Effective Intervention — Oct 2-4, Toronto, Ontario. Information: Yvonne Johns, intervention services, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Canadian Psychiatric Association 35th Annual Meeting — Oct 2-4, Quebec City, Quebec. Information: Canadian Psychiatric Association, Ste 103, 225 Lisgar, Ottawa, Ontario K2P 0C6.

Introductory Addictions Management Course — Oct 7-9, March 17-19, 1986, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto ON M4W 2Y1.

A Day with David Smith — Oct 19, Toronto, Ontario. Information: Yvonne Johns, The Donwood Institute, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Productivity 85 (EAP) — Oct 23-24, Saskatoon, Saskatchewan. Information: Personnel Performance Consultants, Box 7811, Saskatoon, SK S7K 4R5.

Input 85 — The 6th Biennial Canadian Conference on Employee Assistance Programs in the Workplace — Oct 27-30, Ottawa, Ontario. Information: Input 85 Headquarters, Humber College, 205 Humber College Blvd, Rexdale, ON M9W 5L7.

Seminar for Scientists: Alcohol and the Elderly — Oct 31, Toronto, Ontario. Information: Doreen Ross, School For Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Northern Youth in Crisis: A Challenge For Justice — Nov 3-8, Val d'Or, Quebec. Information: Northern Conference Office, c/o Continuing Studies, Simon Fraser University, Burnaby, British Columbia V5A 1S6.

Drug Education Coordinating Council Seminar on Contemporary Drug Issues — Nov 8, Malton, Ontario. Information: H.J. Schankula, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

Orientation to Detoxication Services — Nov 11-15, Feb 24-28, 1986, Apr 7-11, June 2-6, 1986, Toronto, Ontario. Information: Doreen Ross, School For Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Youth, Alcohol and Drugs: A Mini-Conference — Nov 14, Toronto, Ontario. Information: Doreen Ross, School For Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Awareness 85 — 1st Biennial Conference on Employee Assitance Programs in British Columbia — Nov 14-15, Richmond, BC. Information: Awareness 85, c/o 880, One Bentall Centre, 505 Burrard St, Vancouver, BC V7X 1M4.

Skill Training for Employee Assistance Personnel — Nov 17-21, Oakville, Ontario. Information: James Simon, Peel Centre, Addiction Research Foundation, 39 Dundas St E, Ste 203, Mississauga, ON L5A 1V9.

The Emotionally Disturbed Adolescent in the 80s — Nov 22, Toronto, Ontario. Information: Continuing Medical Education, Room 114 FitzGerald Bldg, 150 College St, Toronto, ON M5S 1A8.

23rd Annual Scientific and Business Meeting — Nov 27-30, Toronto, Ontario. Information: Ontario Chapter College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

Alcohol and Other Drugs: You and Your Family — radio course, begins Jan 6, 1986. Information: Open College, 297 Victoria Street, Toronto, Ont M5B 1W1, or School for Addiction Studies, 8 May St, Toronto, On M4W 2Y1.

United States

International Youth Services Conference — Oct 6-9, Chicago, Illinois. Information: Bill Treanor, executive director, American Youth Work Center, 1346 Connecticut Avenue NW, Ste 925, Washington, DC 20036.

37th Annual Convention and Scientific Assembly of the American Academy of Family Physicians (AAFP) — Oct 10-13, Anaheim, California. Information: The American Academy of Family Physicians, 1740 West 92nd St, Kansas City, Missouri 64114.

Alcoholic Beverage Control: Prescription for Public Health — Oct 13-15, San Diego, California. Information: ABC Conference, UCSD Extension, X-001, La Jolla, CA 92093.

5th Annual Northeast Conference on Addictions: The Chemically Dependent Family — Oct 13-17, Albany, New York. Information: US Journal Training, Inc, 1721 Blount Rd, Ste 1, Pompano Beach, Florida 33069.

Children at Risk: Alcohol and the Elementary Student — Oct 17-19, Milwaukee, Wisconsin. Information: Jennifer Gordon, De Paul Training Institute, 4143 S 13th St, Milwaukee WI 53221.

When Chemicals Come to School: Core Group Training for Student Assistance Programs — Nov 4-8, Milwaukee, Wisconsin. Information: Jennifer Gordon, De Paul Training Institute, 4143 S 13th St, Milwaukee WI 53221.

National Federation of Parents for Drug-Free Youth, 4th annual conference — Nov 6-9, Washington, DC. Information: Mary Jo Green, NFP, 1820 Franwall Ave, Ste 16, Silver Spring, Maryland 20902.

Association of Labor-Management Administrators and Consultants on Alcoholism, 14th Annual Conference — Nov 10-14, Boston, Massachusetts. Information: Judith Evans, associate director, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

Association for Medical Education and Research in Substance Abuse, 9th Annual Conference — Nov 14-15, Washington, DC. Information: Dr G. Lewis, AMERSA president, Center for Alcohol Studies, Brown University, Box G, Providence, Rhode Island 02912.

10th Annual Southeastern Conference of Alcohol and Drug Abuse (SECAD 10) — Dec 4-8, Atlanta, Georgia. Information: Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, GA 30342.

Abroad

World Conference of International Christian Federation for the Prevention of Alcoholism and Drug Addiction — Oct 1-6, Limuru, Kenya. Information: Rev J. K. Lawton, General Secretary, ICF-PADA Office, 27 Tavistock Square, London WC1H 9HH, U.K.

International Road Research Documentation (IRRD) System of the Organization for Economic Co-operation and Development (OECD) Plenary Meeting — Oct 8-10, Bergisch Gladbach, Germany. Information: OECD, Road Transport Research Programme, 2, rue Andre-Pascal, 75775 Paris Cedex 16, France.

International Congress on Local Authorities and Drug Policy — Oct 23-24, The Hague, The Netherlands. Information: Municipality of The Hague, Dr N. G. Geerts, MWV, PO Box 80.000, 2508 GA The Hague, The Netherlands.

2nd European Federation of Therapeutic Communities Conference — Nov 17-20, Bruges, Belgium. Information: M. Lutterjohann, Kaiserstrasse 10, D-8000 Munchen.

1st World Congress on Drugs and Alcohol — Dec 15-19, Tel Aviv, Israel. Information: Congress Secretariat, Peltours Ltd, Congress department, POI Box 394, Tel Aviv 61003, Israel.

15th International Institute on the Prevention and Treatment of Drug Dependence — Apr 6-11, 1986, Amsterdam/Noordwijkerhout, Netherlands. Information: ICAA, case postale 140, CH-1001, Lausanne, Switzerland.

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:

a) Regular Line Rates — $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) — $1,000
½ Page (560 lines) — $500
¼ Page (280 lines) — $250
c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation 27,318 (Canada, 21,412, USA, 1,907; Foreign, 386; Bulk, 3,613)
Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year

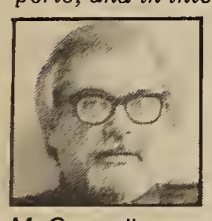
Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount
Ontario residents billed as other Canadians

The Journal, 33 Russell St
Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

AIDS — 'the most significant crisis'

Why do intravenous drug users who develop AIDS die more quickly than male homosexuals who are infected with the same virus? If blood tests show patients have produced antibodies to the HTLV III (AIDS) virus, will they, or won't they, eventually come down with the disease? Should those at high risk of developing AIDS be admitted, or barred from, alcohol and other drug treatment programs? How can legitimate fears about contracting AIDS be dealt with among substance abuse field staff?

These are among myriad questions being asked and pondered by officials from the United States Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), which includes the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The questions appeared in reports, and in interviews with **The Journal**, *at the annual conference in Washington of the Alcohol and Drug Problems Association of North America. Contributing Editor* **Harvey McConnell** *reports.*



McConnell

Macdonald: *'There is no question the virus in the IV drug user pool will travel.'*

Jaffe: *'Are we going to be sued if we admit them; are we going to be sued if we don't?'*

Niven: *'AIDS is going to have a major impact on alcohol and drug treatment programs.'*

Besteman: *'Reporting systems are underestimating the extent to which IV drug users are at risk.'*

Ian Macdonald, MD, ADAMHA administrator, believes the relationship between AIDS and IV drug use has been underestimated. One explanation is the classification system operated by the US Centers for Disease Control: in the past, male, homosexual, IV drug users with AIDS were classed only as male homosexuals.

The spotlight on the spread of AIDS among IV drug users has so far focused on needle transfer; not enough attention has been given to how drug use interferes with the immune system, Dr Macdonald said.

Among IV drug users, the average time between diagnosis of AIDS and death is 10 months; among male homosexuals, the average time between diagnosis and death is 15 months, half again as long. Cause of death is different: among male homosexuals, it is often Kaposi's sarcoma, while among IV drug users it is generally opportunistic disease, especially certain forms of pneumonia.

"I think we have to look back and say we know that heroin, butyl nitrite, marijuana, and alcohol all interfere with immunity and may be doubly related in this discase," Dr Macdonald suggested. A 1983 study of male homosexuals with AIDS found 96% had used butyl nitrite ("poppers") and 88% had used marijuana. Use of a number of other drugs was also high.

Tremendous devastation

Dr Macdonald said: "When you talk about maybe 100,000 people walking around with the virus in the blood and incubating a disease which may take up to six years to appear, we are just seeing the start of tremendous devastation."

While the need is to educate, "the real answer, in my mind, is to increase our efforts to decrease IV drug use. We need to do better case identification in New York and New Jersey and monitor to see that that epidemic is contained. I don't know what we are going to do for those people who are HTLV III antibody-positive."

There is no question the virus in the IV drug user pool will travel; fortunately, at the moment, it is doing so at a slow rate.

Jerome Jaffe, MD, acting director of NIDA, said AIDS among IV drug users is the major issue within the agency, "and we really feel it is going to have an incredible impact not fully perceived by people in the field."

Questions will be raised about how to deal with IV drug users, as well as: "Are we going to be sued if we admit them; are we going to be sued if we don't admit them?"

He said officials from concerned federal agencies are meeting five and six days a week and working long hours, trying to gather the latest information so the field can be informed with a better degree of certainty — "without being hysterical, without exaggerating, but without minimizing either."

No magic solution

The AIDS crisis will be a major force for years to come and, at the moment, there appears to be no vaccine on the horizon. As there is no magic solution, the aim should be to develop effective ways to prevent spread of the disease.

Dr Jaffe added: "I think it is going to be the most significant crisis I can possibly imagine. It is a frightening kind of thing because of the high degree of fatality associated with it; to the best of my knowledge, nobody who has developed clinical manifestations of AIDS has survived.

"Therefore, if staff are a little frightened, or if patients who don't have it are frightened of being in a room with somebody who does have it, it's hard to blame them. It is not going to go away."

Dr Jaffe said the institute assumes that in the same way people ask for information on other issues, they will now ask what is happening about the spread of AIDS and in what groups. It's information people need in order to plan programs.

He said workshops will be held in coming months for people in the field and in single state agencies so they can learn how to deal with drug users and others seeking advice.

One positive note is the tremendous variability of AIDS cases among IV drug users from geographic region to geographic region. Dr Jaffe: "This means that while it may very well be a little late for some places on the East Coast to start real prevention, there are places, like California, with far lower rates, where prevention can have a major impact

Robert Niven, MD, NIAAA director, said that if the AIDS question is not in the forefront of thinking among those involved in treatment programs, it should be. "I don't think there is any question of the fact it is going to have a major impact on alcohol and drug treatment programs."

Consideration must be given to what to do in terms of testing for the presence of the HTLV III virus antibody among potential patients, both for their sake and that of other patients and staff.

He added: "While we can say they have been exposed to the HTLV III virus, what we can't do very readily in those who are antibody-positive is determine whether or not those individuals are actively carrying the virus, or whether or not they have simply been exposed at some time in the past and are no longer potential candidates for transmitting the virus."

Dr Niven added: "There is no definitive body of opinion about what one should do once one has test results. I have heard recommendations which included 'don't test people in the first place.' It is not a recommendation I would personally, as a physician, be comfortable with, and I think not to test them abrogates a responsibility to potential patients."

Speaking as a doctor, and not a a government official, Dr Niven said he "would test patients coming into any program I was running. But, what one does beyond that I think is much more difficult. It has a lot of implications that those running individual programs simply need to sit down and think about and come to some kind of policy."

Dr Niven continued: "I can see programs which will decline to admit anybody who has a history of intravenous drug use, who is homosexual, or who has been a prostitute, because these are clearly the three major risk groups. Prostitutes are not being talked about very much, but, in my view, if you read the literature, it is very clear they are a risk group."

There is the potential for raising a plethora of old issues, "such as druggies vs alcoholics," he said.

Karst J. Besteman, executive director of the Alcohol and Drug Problems Association of North America, and a senior official in the US Public Health Service before retiring two years ago, has no doubts that reporting systems are underestimating the extent to which IV drug users are at risk of AIDS.

"In doing that," he added, "this keeps the field from focusing on a discrete population where we can take some public health interventions to help them reduce the risk of their contracting AIDS. We need to get the word out that they don't share their 'works' with anyone: needle, syringe, eye dropper."

Treatment program personnel need to be well briefed and to start telling patients to get the word to friends who are still shooting not to share. "One does not have to approve of what they are doing to try and stop them getting AIDS."

John French, chief of the office of data analysis and epidemiology with the New Jersey alcohol, narcotics, aud drug abuse control unit, works on the streets and in clinics, trying to educate addicts about the dangers of AIDS and of needle-sharing.

Hypodermic prescriptions

"Sharing is part of the IV drug culture. We have found among those questioned that 95% share needles with heroin, 96% with cocaine, and 97% with amphetamine," he said.

While only 11 of the 50 states require prescriptions for purchase of hypodermic needles, all states have drug laws which prohibit possession if the needles are to be used for illicit drugs, Mr French said.

While IV drug users are frightened of carrying their 'works' with them, Mr French continued, "I know a lot of narcotics agents and I don't know a single nare who would waste his time going out and arresting someone for possession of hypodermic equipment."

However, if prevention is to work, the question will have to be faced one day: will anyone ever take the political risk necessary to make legal, possession of hypodermic equipment for drug use?

Mr French is in no doubt: if the state tells drug users the public health problems are so serious users will be given sterile needles, "that in itself will have an impact. Some of them would be paranoid, but many would stop and think 'If they are doing this, there must be something to it.'"

Harold Ginzburg, MD, assistant to the NIDA director and formerly associate director for clinical medicine in the division of clinical research at the agency, said the geographic distribution of AIDS among drug users appears to radiate from an epicenter in the region of lower Manhattan and Jersey City; the same pattern applies for those tested and found HTLV III antibody-positive.

Most importantly, female IV drug users are at least as at risk of contracting the HTLV III virus as heterosexual male IV drug users. While they do not use drugs as frequently as men, many engage in prostitution or are sexually promiscuous, which increases their risks.

Outlook is grim

Exposure is dose related. "The more you shoot, the more likely you are going to be exposed to the virus that produces the antibody," said Dr Ginzburg.

He said the outlook is grim: the number of AIDS cases is approaching 13,000 overall, and "next year at this time I will be in front of you and say we have 25,000 cases and already have 13,000 dead."

From an epidemiological point of view, "we are dealing with an epidemic which is spreading, and, if we are going to have preventive activities (among IV drug users), we damn well better concentrate on the cities that have low rates or relatively low rates and where we can do something."

Among cities, New York has the highest rate of AIDS cases per million of population, followed by San Francisco, Miami, Newark, and Los Angeles. (Washington, DC, is in eighth place.)

Dr Ginzburg said people continually ask if drug use intrinsically suppresses the immune system. "And, the answer is 'yes.' We have data on heroin, certainly the nitrites, and some preliminary data on marijuana, and all this indicates there are alterations in the immune system independent of the contaminants or adulterants that are used in the drugs."

He anticipates studies being carried out by NIDA on practices in New Jersey, where needles and syringes are hard to come by, aud in Louisiana, where they are easy to obtain, will show little difference in the IV drug culture habit of sharing. "We have got to change the primary behavior. When we have changed the primary behavior, then the issue of needles will have to be dealt with."

Marc Rose, PhD, of the prevention research branch at NIDA, said when IV drug users are diagnosed as having AIDS, they leave the drug culture and return to their families. "They go home to die."

A NIDA quiz used on 189 people attending a methadone maintenance clinic in New Jersey found from 88% to 95% were aware of AIDS, of how it was transmitted, and of the risks. But, a surprising number were unaware of how lethal the disease is.

Dr Jaffe said people involved with IV drug users will have to "grasp the nettle" and tell users the truth if they develop AIDS. Users should also be instructed on how not to transmit it to friends.

"That is the best you can do for them. The only legacy they can leave to their friends is that they leave them alive."

THE BACK PAGE

Hockey stars assist RCMP anti-drug team

Coffey: tough to walk away

By Elda Hauschildt

TORONTO — While the National Hockey League (NHL) swings into its regular season play, eight top-ranking players are reserving personal time-outs to help with a Canadian drug prevention program.

Paul Coffey of the Edmonton Oilers, Michel Goulet of the Quebec Nordiques, Larry Robinson of the Montreal Canadiens, Gary Nylund of the Toronto Maple Leafs, Dale Hawerchuk of the Winnipeg Jets, Paul Reinhart of the Calgary Flames, Tony Tanti of the Vancouver Canucks, and Rod Langway of the Washington Capitals are headlining the fifth year of the Royal Canadian Mounted Police's (RCMP) drug prevention campaign.

Sergeant Michael Pelletier of the RCMP's Montreal drug section, who initiated the program, told **The Journal** the NHL was chosen as the program's focus because "the organization is strict in its own security and uses drug education programs" itself.

Both the NHL and individual team managements cooperate with the RCMP so that players are available for public speaking during the playing season.

Aimed at Canadian youth, the RCMP national campaign requires players to make advance commitments to work in their home or team areas with local RCMP officers.

"I know how hard it is for kids, especially in their early teens; it's just too easy to be persuaded to get into drugs," Paul Coffey told **The Journal.**

"Peer pressure has to be the worst thing for teenagers. It's hard to cope with it to begin with, and it's even tougher to walk away when people start talking drugs. The kids need to know other people have been through this — that it is okay to say no."

Mr Coffey says he would like to use his personal experience in junior hockey to get the prevention message across.

"I took a lot of guff back then for sticking to my training routine, for not smoking or getting into other things. If I can help even two or three of the kids who come out to hear me, if I can make them realize 'hey, we don't have to do this,' then my time will be worth it."

Vol. 14 No. 11 2nd Class Mail Reg No. 2776 TORONTO, November 1, 1985

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Urine tests in US schools on trial

By Betty Lou Lee

VANCOUVER — Some United States schools are using cannabis metabolite urine tests to screen students for admission, or participation in athletic programs.

Students with positive tests may be refused admission unless they agree to take part in a drug abuse program.

George Comerci, MD, a specialist in adolescent medicine at the University of Arizona College of Medicine, Tucson, says that although the schools' right to do this is being challenged in the US courts as a civil rights issue, many parents in his area — the southwest — consider the tests a good idea.

Dr Comerci was one of several specialists in adolescent medicine taking part in a symposium on violence in youth at the annual meeting here of the Canadian Paediatric Society.

He says alcohol and other drug abuse is the major cause of death and disability in North Americans 15 to 24 years old, most frequently as the result of accidents.

Accidents kill 38,000 people a year in that age group in the US. Sixty percent are traffic accidents, half of them related to alcohol or other drugs.

Another 6,000 young people die from suicide and 5,000 more from homicide, many involving chemicals.

Richard MacKenzie, MD, director of adolescent medicine at the Children's Hospital of Los Angeles, says this is the only age group for which death rates are not going down. In 1961, homicide wasn't a common cause of deaths among the young, but it is now in fourth place, following traffic accidents, suicides, and cancer. It is in first place in low socio-economic groups.

Dr MacKenzie says 49% of patients in his high-risk youth project use alcohol, 32% marijuana, and 15% stimulants (mostly cocaine). But, only 3% consider they have any problem with drugs.

"Boredom is a major thing in young people's lives; there isn't enough to turn them on. When you have to hang around a shopping mall for something to do, that's boredom."

Dr MacKenzie sees adolescents as commercial targets — whether it's Madison Avenue selling designer jeans or pushers selling drugs. Because juveniles are protected under law, they are also victims of pushers who use them to spread drugs or commit burglaries.

Both specialists agree the most effective way of preventing substance misuse is early education to promote self-esteem, at home and school.

Native children hardest hit

FAS crippling kids in Far North

By Betty Lou Lee

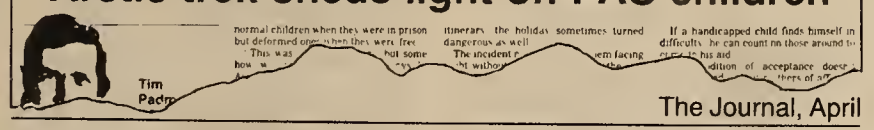
VANCOUVER — Fetal alcohol syndrome (FAS) was the commonest cause of mental retardation found in a study of chronically handicapped children in the Yukon and northwest British Columbia.

Of 586 children up to 16 years old, 176 (30%) were identified with FAS or fetal alcohol effects (FAE); of those, 88% had learning disorders or mental retardation, and 94% were Native children.

Kwadwo O. Asante, MD, of Mills Memorial Hospital, Terrace, BC, (**The Journal**, April) presented the results of the study to the annual meeting here of the Canadian Paediatric Society.

'A Native society in the process of change'

Arctic trek sheds light on FAS children



Tim Padm

The Journal, April

Mothers drank more than two drinks a week in 51% of the total pregnancies and 72% of the Native ones.

Dr Asante says most mothers were unable to give an accurate account of how much they drank during a particular pregnancy, especially for one from many years ago. But, information from public health nurses, social workers, and family members was obtained when possible.

"Not all mothers of affected children were chronic alcoholics — many engaged in frequent drinking with weekly or fortnightly consumption of several drinks.

"Most mothers were aware of the possible harm of alcohol to the fetus, but drank 'only beer,' which they perceived to be less harmful than whisky, vodka, and other spirits. In most cases, the women drank because spouses were drinking.

"In most of the communities surveyed, alcohol abuse is considered a tolerable social misdemeanor."

The Yukon has the highest per capita consumption of absolute alcohol in Canada, followed by the Northwest Territories and BC. (For more Canadian alcohol and other drug statistics, see Stats•facts, pages 11, 12.) In 1980, per capita consumption was more than 22 litres in the Yukon, and about 13.5 litres in the other two jurisdictions.

(See FAS, p2)

World crime congress spotlights drugs

By Thomas Land

MILAN — A world congress here on crime has called for an international legal instrument to assist law enforcement authorities in their war on drug smugglers.

Beatty: crucial to Canada

The instrument would allow the search on the high seas of vessels suspected of drug-running, provide for improved measures at ports and free-trade zones to ensure pharmaceuticals and other chemicals in transit are intended for legitimate purposes, and facilitate the seizure of the financial profits of organized crime. The resolution was sponsored by 20 countries including Canada, Britain, the United States, Australia, and New Zealand.

An international convention against drug traffickers is already under discussion by the United Nations. The resolution carried here at the UN 7th International Congress on the Prevention of Crime and Treatment of Offenders may well influence the outcome of debate about the proposed new UN treaty, also against traffickers (**The Journal**, October, April).

The congress — attended by leading criminologists, penologists, and senior police officers, representing 120 countries, as well as individual experts on criminal law, human rights, and rehabilitation — was concerned with a wide area of endeavor. But, much of its attention was devoted to drug smuggling, partly because of its rapidly-spreading and disastrous effects on society, and partly because it is increasingly associated with other crimes, such as international terrorism, piracy, and fraud.

Canadian Solicitor-General Perrin Beatty says the proposed global measure for forfeiture of the proceeds of illegal drug transactions is "a matter of crucial importance" to Canada.

Canada, he told the conference, has enacted legislation which makes it an offence to possess the proceeds of drug trafficking, even if the trafficking has taken place in another country. Canadian courts have successfully ordered the forfeiture of the proceeds of drug-related crime and are in the process of defining the law and procedures to assist in delineating the scope and effectiveness of existing legislation.

Toronto criminologist Dahn Batchelor addressed delegates on international terrorism, which is being financed increasingly from drug transactions. Speaking as an individual expert, he called for early trial and execution of terrorists caught in the act, with only brief public announcements to follow.

D. Lowell Jensen, US deputy at-

(See Trafficking, p2)

INSIDE

NEWS

Briefly...

A potent smoke

LONDON — Two million cigarettes have been removed from sale here following reports of cyanide contamination, says *The London Sunday Times*. The action was sparked by a handwritten inscription inside one purchased package which read: "These cigarettes have been impregnated with cyanide. Animal Rights Liberation Front."

Kilobyte craze

LONDON — Computer-obsessed kids are becoming addicted to their equipment, says Scottish psychiatrist Prem Misra. The doctor has treated four teenage boys for excessive daydreaming, nightmares, psychosis, and exhaustion, says *The Toronto Star*. While three of Dr Misra's patients were weaned away from their "addiction," one had to be hospitalized and treated with tranquillizers. The boys had been spending up to 12 hours a day playing computer games.

India gets tough

NEW DELHI — Draconian anti-drug measures have been approved by the Indian Parliament. Traffickers now face prison sentences of between 10 and 30 years and fines of up to $25,000 says *Reuters*. Approval came as a United States congressional delegation arrived here to hold talks with senior Indian officials on narcotics and drug enforcement measures.

'Putting on the Ritz'

OTTAWA — Fashion-conscious female smokers in the United States are the latest target of the tobacco giant R.J. Reynolds Company. 'Ritz' cigarettes, created in association with fashion designer Yves Saint Laurent, are now being testmarketed to see whether consumers are ready for a premium-priced smoke. The cigarettes bear the world-famous, much-brandished YSL logo, says the *Canadian Council on Smoking and Health*.

Deathly protection

NEW YORK — Well-meaning secretaries are "protecting to death" their alcoholic executive bosses, says a study by the *Alcoholism Council of Greater New York*. The Council found that alcoholic presidents and chief executive officers of some companies are able to keep their jobs because: their secretaries develop elaborate "cover-up" schemes; their peers protect them; and, they come to work early, stay late, and work on weekends to compensate for time lost drinking during normal working hours.

Drug tests in jails

OTTAWA — Canada's federal penitentiaries may soon have the authority to take urine samples from prisoners to track illicit drug use, says *The Globe and Mail*. The federal Cabinet has approved the tests, but they will not begin until Correctional Service Canada decides how to do them.

This stimulant epidemic isn't going away

Story of cocaine is scary: Cohen

By Harvey McConnell

WASHINGTON — The reality of cocaine use is so frightening, scare tactics are not needed.

That's the conclusion of Sidney Cohen, MD, professor, Neuropsychiatric Institute, School of Medicine, University of California Los Angeles, in a new monograph he has written for the American Council on Drug Education here.

Dr Cohen, who has treated scores of cocaine addicts, travelled to South America earlier this year to update his monograph, *Cocaine: The Bottom Line*, which followed one he wrote for the council in 1981. He concludes: "The outlook looks dismal.

"The public health aspects of the cocaine story may no longer be the major adverse consequence, even though morbidity and mortality are mounting.

"It is the disorganizing impact of the many billions of 'coca-dollars' on the producing and the consuming nations that produces a level of corruption, violence, and demoralization that damages everyone."

While most people now consider that scare tactics are counterproductive and should be avoided,

Cohen: reality scary enough

"the expanding, really exploding, cocaine story itself is scary."

In the monograph, Dr Cohen deals with the paradoxes of cocaine, a "dozen ways to die with cocaine," and suggests future action.

The prime paradox is "what starts out as a fun thing turns out, all too often, as a disaster. Euphoria ends up as dysphoria; high turns into low."

Dr Cohen says two years ago he would have predicted the cocaine outbreak would go away because most stimulant epidemics have short lives. The amphetamine craze began around 1970 and had ended by 1975, for example.

That has not happened with cocaine, and part of the problem is a massive oversupply of the drug, despite enormous numbers of drug busts, destruction of laboratories, and uprooting of thousands of coca bushes. "The more you destroy, the more there is."

Another paradox: "While the end stages of compulsive cocaine use include some of the most miserable of human conditions, in the beginning it is joy and excitement." For these reasons, those who are social users at the moment "are busily proselytizing for the drug and turning friends on," and not understanding the drug's danger.

Dr Cohen lists a dozen ways to die with cocaine: overdose, hypersensitivity to the drug, hypertension and cerebral hemorrhage, hyperpyrexia (raised body temperature), major convulsions, myocardial infarction, suicide, homocide, accidental death through impaired judgement, reduced immune state, blood stream infections, and interaction of cocaine with other drugs.

Coca-bush growing is the only cash crop possible for many South American peasants, and major traffickers try to present themselves as revolutionaries robbing the rich to give to the poor. However, traffickers may have made a fundamental error in allowing coca-paste smoking to become endemic among young people (**The Journal**, May, 1984).

By addicting a significant part of the population in cocaine-producing countries, traffickers have produced reaction from governments "motivated more out of anger about what is happening to their citizens, than by pressure from the outside," Dr Cohen says.

As control of supplies is not a realistic goal now, thought should be given to demand reduction and prevention, Dr Cohen says. This includes special education programs and people taking responsibility for their actions.

Dr Cohen: "Responsibility for one's self and society has not been well instilled into children and adolescents in recent years. The problem has always been externalized. It's 'out there.' Despite the obvious shortcoming of the social system, the responsibility for our own conduct remains the final barrier to harmful comportment."

Trafficking treaty seen as a priority

(from page 1)

torney-general, called the social implications of drug abuse profound and pernicious. Drug trafficking tempts public officials more than any other criminal activity, he said, and it can no longer be viewed on a national or regional basis.

Mr Jensen: "The jurisdictional issue of drug trafficking on the high seas must be solved, and there must be effective systems of control of substances used in the production of drugs. Drug trafficking will not be controlled until the demand for drugs is eliminated . . . . In the common interest, a stronger, international network must be formed for combating international trafficking."

John H. Langer, assistant director of the International Association of Chiefs of Police, told the conference: "Drug trafficking has emerged as an unprecedented threat to the stability of world order and the integrity of nations.

"The evidence is so convincing that, even in the absence of classified intelligence reports, it would be possible to identify many areas where corruption has made serious inroads, destabilizing institutions and threatening anarchy."

He said it is virtually impossible for small, developing countries involved in the drug trade to defeat traffickers without external assistance. And, he appealed for measures to stop the flow of funds generated by the drug trade before they are reinvested.

The resolution, which is now to be put before the UN General Assembly, which itself catalyzed current discussion by the UN Commission on Narcotic Drugs on a new international treaty against traffickers, seeks widening legal provisions to back such a strategy. The Milan resolution invites all UN member countries and international organizations to consider the proposed legal instrument on drug trafficking as a matter of absolute priority.

Laundering of drug money under fire

By Thomas Land

ROME — The West is seeking fundamental changes in international law enabling national enforcement agencies to stop and search vessels on the high seas if they are suspected of drug running.

The Italian proposal is high on a list of objectives agreed to by specialists from Western Europe and North America in joint preparation for a proposed world treaty on drug trafficking. They also want measures to prevent the "laundering" of assets generated by the drug trade and to enable authorities to seize the profits of traffickers.

Italy has long campaigned for changes in the law to enable its coast guard to intercept drug runners beyond its territorial waters before they approach the country's long, exposed shorelines. The issue is complicated by the United Nation's recent Law of the Sea Convention, which upholds the right of unhindered passage in the high seas, and by the sensitivity of recently-independent countries which want to protect that right.

But, it is equally in the interest of all countries to prevent drug smugglers on the high seas from sheltering behind the Convention. "Certain vessels, protected by international legislation, can move freely in international waters and dump their wares or supply small boats off the French, Italian, or Spanish coasts," says a Council of Europe discussion paper describing drug running in the Mediterranean.

Virtually all international traffic of narcotics is directed to the rich countries, and virtually all crop substitution projects in the opium and coca growing areas are financed by the rich countries. The donors regard the investment as a form of collective self defence. But, so far, it has failed to stem the tide.

FAS prevention work vital

(from page 1)

Chronic handicap was defined for the study as any physical, sensory, or developmental problem that prevented a child from performing normally in preschool development or produced significant learning problems or physical disability.

Physical abnormalities were found in 45% of the children, sensory abnormalities in 31%, and developmental handicaps in 56%. (Some had more than one problem.)

The prevalence of FAS/FAE in the Yukon was found to be 46 per 1,000 for Native children, and 0.4 per 1,000 for non-Native children. In northwest BC, it was 25 per 1,000, and 0.4 per 1,000 respectively.

As primary preventive measures, Dr Asante suggests education of the general population, especially women of childbearing age and their husbands, children in school, and health care professionals.

Secondary measures should include services such as halfway homes to assist pregnant women who drink, early identification of children at risk, and early, remedial actions for identified problems.

Correction

In the October issue, on page 7, R. A. (Ron) Draper was identified as director-general, health protection branch, Health and Welfare Canada. He is, of course, director-general, health promotion directorate, Health and Welfare Canada.

NEWS

Alberta medics want agency to counter tobacco goliaths

CALGARY — Alberta physicians want the provincial government to spend $40 million to set up an autonomous agency to do battle with the tobacco companies. At stake, they say, is the health of Alberta's population.

The resolution to support establishment of such an agency was one of several anti-tobacco recommendations made by doctors at the annual meeting here of the Alberta Medical Association (AMA).

Roger Hodkinson, MD, a pathologist at Edmonton's Misericordia Hospital, is president of the Group Against Smoking Pollution (GASP) in Alberta. He told the AMA a new agency is needed to counter the estimated $10 million which the tobacco industry spends on tobacco promotion in Alberta every year.

Dr Hodkinson says 3,000 Albertans a year die from tobacco-related illnesses. But, there is currently little to counter the industry, except "a fragmented collection of organizations and governmental departments with meagre resources."

Dr Hodkinson proposes an annual budget for the new agency of $40 million — which he says could be raised by increasing the provincial tobacco taxes by 40%. He says the agency would not be prohibitionist, but would attempt "to prevent people from starting to smoke, and support in every conceivable way those who wish to quit."

AMA members supported the resolution with little debate, thereby joining the Alberta Public Health Association, which, earlier this year, supported the same resolution.

Other resolutions against smoking came from the AMA's communications committee, whose chairman, Neil MacDonald, MD, said tobacco-related deaths in Alberta far exceed deaths due to AIDS (acquired immune deficiency syndrome). "Where's the headlines, where's the public outcry?" he asked.

A resolution to ask newspapers voluntarily to ban advertisements of tobacco products was adopted at the meeting, as was a motion to raise the provincial tax on tobacco. Alberta currently has one of the lowest, if not the lowest, such tax in Canada.

Another resolution to ban the sale of tobacco products on hospital premises also received widespread support.

The Red Deer physician who made the proposal said he hoped AMA support would help make his hospital's board of directors act.

Economic, political realities bring competitiveness

Private enterprise climate threatens treatment

By Harvey McConnell

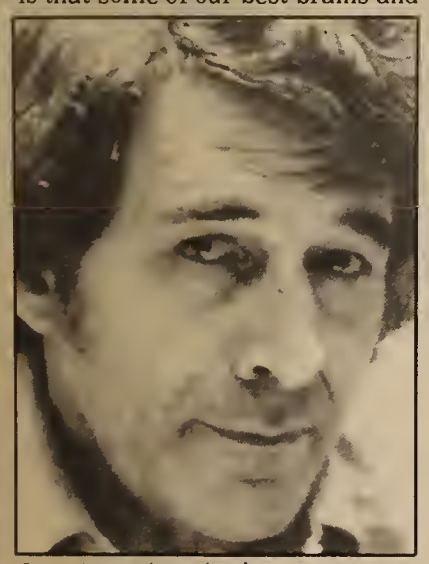
WASHINGTON — Development of private, and costly, treatment programs for alcohol and other drug dependence is accelerating in the United States and, in some ways, jeopardizing the status of Alcoholics Anonymous (AA).

This was the consensus of a panel of three experts at the annual conference here of the Alcohol and Drug Problems Association of North America.

Donald Ottenberg, professor at Temple University Medical School, Philadelphia, and a past director of Eagleville Hospital, Eagleville, said he worries about "the privatization of the drug and alcohol field" in response to current political and economic realities.

"We have entered a very competitive era in this field, an era of tremendous, rapid growth and all kinds of new programs.

"Of particular concern, I think, is that some of our best brains and some of our most respected creativity is going into the issues of competition and survival, rather than into the creation of really important responses at either the program level or the community level."



Ottenberg: best brains

Peter Brock, a private consultant here and former director of the Johnson Institute in Minneapolis, said there has been an increasing number of people in the field moving to a much narrower advocacy "on behalf of part of our industry, if you will, and increasingly less advocacy for the population in need and for the alcohol and drug dependence field generally."

The increased success in developing treatment resources has been matched by a more competitive climate.

Mr Brock said he is increasingly concerned as well at the way AA is being used as a resource for treatment programs. These programs attempt to tie their graduates to AA out of all sorts of reasons, "not the least of which, I am sure, is that it is the most significant referral source most of them have. Further to that, in many communities AA is no longer seen as an independent resource but as some sort of adjunct to treatment."

If this were to continue it would have unfortunate implications for the field and for the population in need.

Shirley Coletti, chairman of the board of the National Federation of Parents for Drug-Free Youth, said that community-based programs for adolescents are relatively nonexistent in the US. Many people "turn to private, 'magic-cure' 28-day programs which, unfortunately, are really duping a lot of parents." (**The Journal**, December, 1984.)

"I think this is an issue which really has to be resolved because you can't put an adolescent in a 28-day treatment program and expect him or her to be fixed at the end, unless you fix mom and dad, or you fix the family along with the youngster."

An increase in competition for clients has brought a willingness in some areas to reduce standards of care and reduce requirements for care givers, Mr Brock added. "We have got to look at whether our decisions are being made clinically, or whether they are being made economically, or whether there is some sort of reasonable balance between the two."

More teens, more accidents

Student driver courses backfire

By Betty Lou Lee

VANCOUVER — High school driver education programs should be eliminated, says the director of the Injury Research Unit at the University of Calgary, following a five-year study of adolescent traffic deaths in Alberta.

John H. Read, MD, says such programs increase the number of 16 and 17 year olds who are licensed to drive, without decreasing crashes per licensed driver.

He found that from 1981 to 1982, 116 teen drivers were involved in accidents that led to 199 deaths (83 drivers and 116 occupants) and 193 injuries.

At least 40% of teenaged-driver deaths were associated with alcohol, and at least 35% of occupants killed had been drinking.

Twelve of the drivers killed from 1978 to 1982 were less than 16 years old. Alberta is the only province that allows "learner permits" at 14 years, although its licensing age is 16 years, as it is in all other provinces except Newfoundland, where it is 17 years.

Alberta is also one of three Canadian jurisdictions without mandatory seat belt legislation, and one of four where the minimum drinking age is 18 years. In other jurisdictions, it is 19 years. Alberta also has a higher highway speed limit — 110 kilometres per hour (66 miles per hour) — than most other jurisdictions.

Teen drivers: encouraged but not protected by courses

Two-thirds of Albertans aged 14 to 19 years have a driving permit.

Nine percent of 527 teenagers killed in motor vehicles from 1978 to 1982 were Native Canadians, although Natives make up only 2.4% of the Alberta teen population.

In addition to his suggestion on school driving programs, Dr Read recommends that adolescent driving licences be conditional on seat belt usage, with strict enforcement; that the drinking age be raised; and, that the driving age be raised to 17 years. He says restricting night-time driving "could halve the crash involvement of 16 year olds during late night and early morning hours."

Experts will lobby WHO for better alcohol casualty stats

TORONTO — The link between alcohol and such chronic conditions as cirrhosis and alcohol psychosis is well documented, but the statistical picture on casualties related to alcohol is full of holes, says a research scientist from the Addiction Research Foundation (ARF) in Ontario.

In reporting casualties, doctors need a specific category on alcohol-related casualties if reliable statistics are ever going to be accumulated on alcohol's involvement in such traumatic events as rape, boat accidents, and family violence, Norman Giesbrecht, PhD, told **The Journa**l. Only through such statistics will a clearer picture of the human cost of alcohol consumption emerge.

One positive move to consistency would be to lobby the World Health Organization (WHO) for revision of the International Classification of Diseases (ICD), he says. (The ICD comes up for revision every seven years, and medical groups are able to make recommendations.)

A small, international group of experts meeting here recently has agreed to do just that, says Dr Giesbrecht. Their symposium drew participants from 21 countries.

The focus of the revision they will suggest will be the "E code," a listing for various kinds of casualties. Currently, there is only one subcategory — alcohol poisoning — in which a doctor can note whether alcohol was a factor in the casualty.

Roberta Ferrence, an ARF epidemiologist and symposium participant, says, for now, statistics on alcohol involvement in injuries and deaths are routinely gathered only for motor vehicle accidents.

"Reliable statistics on alcohol involvement in other accidents aren't kept. Therefore, policymakers can't revise requirements for licences, for example," she said.

Giesbrecht

Ferrence

"We just can't coast along saying people had been drinking without knowing the exact relationship" between drinking and the accident.

To obtain such statistics, Dr Giesbrecht says, the symposium has recommended emergency room personnel routinely note alcohol involvement on patients' charts. This would be done first by measuring the patient's blood alcohol level, and secondly, by interviewing the patient to establish drinking patterns.

He says the intoxication level could be measured in a comatose patient by a "dip-stick" method, using a specially-treated stick to test the patient's urine or saliva. The color the stick turns accurately indicates the alcohol level. (**The Journal**, June, 1984; August, 1983).

Participants at the conference were interested in setting up studies in emergency rooms incorporating this method, Dr Giesbrecht says.

Statistics-gathering in developing countries was another problem discussed. These countries "don't have comprehensive and highly detailed systems of regular reporting," said Dr Giesbrecht.

A solution proposed was the "snapshot" method of data gathering, using samplings of alcohol involvement in injuries done on a certain day in a certain week, then repeated on a regular basis.

Dr Giesbrecht says symposium participants also plan to:

- improve the quality of information available on the relationship between consumption of non-commercially made alcohol, such as home brew, and casualties;
- pull together studies on differences in casualty patterns after dramatic changes in the availability of alcohol — when liquor is banned in an outlying area, or a strike stops the sale of alcohol; and,
- develop a questionnaire to send out to those gathering casualty statistics — police, ambulance systems, coroners' offices. The questionnaire would deal with documentation and how alcohol involvement can be reported accurately.

The Toronto symposium was sponsored by the ARF, the WHO, the United States National Institute on Alcohol Abuse and Alcoholism, and Health and Welfare Canada.

NEWS

RESEARCH UPDATE

Non-smoking may cure Ekbom's syndrome

Smoking cessation may cure Ekbom's disease. The disease tends to affect middle-aged women and causes a disagreeable irritation deep inside both legs, which can only be relieved by walking about. J.A. Mountifield, MD, associate professor, department of family and community medicine, University of Toronto, said giving up smoking cured the syndrome in a 70-year-old woman. She had smoked about 25 cigarettes daily for 50 years and had complained for several years of insomnia caused by unpleasant sensations in her legs. Dr Mountifield said laboratory investigation ruled out iron-deficiency anemia, folate deficiency, diabetes, and uremia, all known causes of the condition. Various drugs and other aids had failed to relieve the symptoms until the woman stopped smoking abruptly following a stay in hospital for asthma. Dr Mountifield: "Seven weeks later, she reported the restlessness of her legs had completely disappeared about a month after she had stopped smoking. Four months later, she was still free of restlessness in her legs." He concludes it is difficult to explain by what mechanism the cessation of smoking had cured the disease.
Canadian Medical Association Journal, Sept 1, 1985, v.133:426-427.

Rats deteriorate with cocaine

The dangers of long-term cocaine abuse have been highlighted by a study which gave laboratory rats unlimited access to either intravenous cocaine hydrochloride or heroin hydrochloride. Michael Bozarth, PhD, and Roy Wise, PhD, from the Centre for Studies in Behavioral Neurobiology, department of psychology, Concordia University, Montreal, allowed the rats to self-administer the drugs and evaluated their behavior and drug intake for a period of up to 30 days. They found that while those animals with access to the intravenous heroin gradually increased their intake during the first two weeks and showed a stable pattern of self-administration thereafter, the animals self-administering intravenous cocaine developed an episodic pattern of intake, with periods of excessive drug use alternating with brief periods of abstinence. The animals on intravenous cocaine had a far more pronounced deterioration of general health and weight loss than the animals self-administering heroin and, most strikingly, the 30-day mortality rate for the cocaine group was 90% compared with 36% for the animals self-administering heroin. The researchers said this indicated cocaine is much more toxic than heroin when animals are allowed unlimited access. They said the results imply that as cocaine intake increases in the human population and the concentration of the drug becomes greater because of free-basing or through the availability of higher-purity batches, the mortality rate associated with cocaine abuse is likely to increase.
Journal of the American Medical Association, July 5, 1985, v.254:81-83.

Dysphoric patients shun naltrexone

Naltrexone treatment dysphoria may be one reason for the high non-compliance rate among former opioid addicts taking the drug to prevent relapse, says a study from the University of Colorado School of Medicine. To test why as many as 90% of patients drop out of naltrexone treatment regimens by the eighth month, researchers tested the drug on four men who had been free of opioids for nine to 44 months. Under a six-week, placebo-controlled, crossover design, subjects received naltrexone tablets in a dose increasing from 50 milligrams to 150 mg three times a week for a three-week period, and placebo for an equivalent period. Throughout the study period, subjects completed a number of questionnaires, including self-ratings of mood. One subject dropped out of the study after the first medication week with drug abstinence-like symptoms. Two of the remaining three patients reported mild but significantly greater dysphoria during periods of naltrexone administration. The most dysphoric scores were those recorded during 24-hour spans immediately following administration of the drug. The researchers conclude naltrexone may induce mild dysphoria among at least some former addicts not recently exposed to opioids. The unpleasant mood state could contribute to non-compliance during naltrexone therapy.
American Journal of Psychiatry, Sept 1985, v.142:1081-1084

Fatty acid an alcoholism marker?

Palmitoleic acid — an unsaturated fatty acid — may have value as an independent marker of alcohol consumption, say French researchers. In an epidemiological study of 1,467 Parisian working men between the ages of 35 and 45 years, researchers at the *Groupe d'Etude sur l'Epidémiologie de l'Athérosclérose*, looked at alcohol consumption and food intake during a 24-hour period. They measured two markers of high alcohol consumption — γ-glutamyltransferase and mean corpuscular volume — as well as the composition of fatty acids in plasma cholesterol esters. In the study group, the mean alcohol consumption was 34.6 grams per day, mainly in the form of wine. Of the 13 fatty acids identified, only three, palmitoleic, oleic, and linoleic, were associated with alcohol consumption and its biologic markers. When a statistical analysis was undertaken using these variables and the fat content of the diet, palmitoleic acid was the only fatty acid that continued to be significantly correlated. The researchers said this correlation "is consistent with the observation that the proportion of this fatty acid in adipose tissue best differentiates alcoholics from non-alcoholics." For this reason, they conclude, palmitoleic acid appears to be an independent marker of alcohol consumption and could be used in epidemiological or clinical studies in conjunction with other markers.
British Medical Journal, June 22, 1985, v.290:1859-1861.

Pat Rich

Alcoholics ho-hum deviants say general hospital MDs

By Pat Davies

TORONTO — The negative attitude of doctors is the biggest roadblock to effective treatment for alcoholics in general hospitals.

"It (alcoholism) is simply considered deviant behavior, and we don't want to deal with it," Gerry Burrow, MD, physician-in-chief, Toronto General Hospital, told a seminar here.

The problem is not confined to Canada: "I spent 20 years at Yale (University, New Haven, Conn). The problem is worse there. We simply ignored the idea in the United States."

Dr Burrow, also chairman of the department of medicine, University of Toronto, says the literature on general hospitals and alcoholism consists of material on complications, such as the effects of alcohol on the central nervous system, and liver diseases, but nothing on treatment.

"Everybody is willing to deal with the complications, but not the disease."

James Rankin, MD, head of medicine at Ontario's Addiction Research Foundation (ARF) cited reasons for the indifference.

"Alcoholics are a lot of trouble; they won't stop drinking." That is a common attitude when an alcoholic is admitted to a general hospital ward, he said.

Also, there is no tradition of general hospitals giving help in this area. They see the problem as someone else's responsibility — "another hospital can fix these people up."

Hospitals ignore the problem of alcoholism so well "a person can be in the hospital system for 20 years" before doctors recognize that the presenting problems, such as injuries, are related to alcohol abuse, Dr Rankin said.

One reason doctors don't address alcoholism effectively is they feel helpless to deal with it, he said. He cited a 1983 US survey of physicians, which showed 46% of doctors were prepared to counsel patients about alcohol, but only 3% were confident their intervention would help.

Prevention is slow, steady work with "no rewards in the health care system for doing a good job," Wilfred Palmer, MD, family physician-in-chief at Toronto General Hospital, told the seminar.

Dr Palmer would like to see incentive money made available if, for instance, prevention programs reduce the number of alcoholic admissions to a hospital.

Another problem for physicians is that dealing with alcoholism "isn't like doing a heart-lung transplant; there are no fireworks."

There were 22 hospitals represented at the seminar, on responses to alcohol and drug problems, sponsored by ARF's hospital outreach service.

Today's alcoholism care is hypertension revisited

TORONTO — Doctors are dealing with alcoholism in the same way they dealt with hypertension 20 years ago, says the chairman of family and community medicine at the University of Toronto.

Wilfred Palmer, MD, told a recent seminar on the response of general hospitals to alcohol and other drug problems that the incidence of hypertension in the early 1960s was about 10% of the adult population. A recent Gallup poll shows one in 10 respondents consider they have a drinking problem.

Said Dr Palmer, also family physician-in-chief at Toronto General Hospital: "Twenty-five years ago, we were very concerned with the complications of hypertension, like stroke, heart and kidney failure. Then, we had to go back and find out how to intervene earlier in the disease."

Doctors are now missing the early signs of alcoholism and intervening only after the patient has gotten into serious trouble with a car accident or liver damage, he said.

Twenty-five years ago, medical schools taught what Dr Palmer calls "the $1,000 work-up on hypertensive patients," which included a battery of complicated tests.

Today, the diagnosis involves a few simple tests, the most important being the taking of a patient's blood pressure.

Dr Palmer says the test for alcoholism could be equally simple: a few, pertinent, carefully directed questions to patients.

On treatment, he said, the same ratio seems to apply today for alcoholics as applied in the early 1960s to hypertension, when only one in eight patients was receiving proper treatment.

Early results are encouraging

Courses augment DWI probation

By Betty Lou Lee

HAMILTON — Educational programs as part of probation for convicted, impaired drivers are showing encouraging early results in preventing recidivism in Ontario.

In Ottawa, only two drivers have been re-convicted in the seven years the program has been operating. In Willowdale, none has had a recurrence in 18 months. And, in London, where the program started two and a half years ago with parolees and probationers with extensive criminal records, 92% haven't had any criminal convictions since finishing the program.

Three of the programs were described at the 26th annual Institute on Addiction Studies held here by Alcohol and Drug Concerns, Inc (ADC).

In Willowdale, first offenders attend an eight-week program as part of a one-year probation and can be taken back to court for a breach if they don't comply. None has, says Lorraine Joynt, a probation and parole officer. Although they automatically lose their licences for three months, lack of transportation is not accepted as an excuse for being late or missing a session.

Drivers who expected to just leave court and pay a $300 fine are often "quite upset" with the probation, especially businessmen who resent having to associate with other probationers, she said.

The sessions include questionnaires, tests, and interviews about their knowledge, attitudes, and alcohol use patterns. A physician, addictions counsellor, police officer, and insurance agent explain various ramifications of drinking and driving and alcohol abuse. A lawyer explains that they now have a criminal record and could be barred from certain jobs.

Rudy Janzen of ADC is Toronto coordinator of the program, called SIPIT — Stop Impaired Probationers.

If they complete the course and have no alcoholism, financial, or employment problems, participants no longer have to report to their probation officers.

Follow-up shows many have reduced their drinking, "their marriages are better, and they feel better about themselves," said Ms Joynt.

The London program started at the other end of the scale, with parolees addicted to any number of substances and convictions as serious as attempted murder — one had been in 35 institutions. It is now starting to get first offenders for impaired driving as the program has gained more acceptance within the judicial system.

The program is contracted out to the Salvation Army Correctional Services. Its coordinator is Bernadine Bechard, who is also president of the Council for Action on Alcohol and Other Drugs.

It, too, has eight weekly sessions with guest speakers and lectures by Ms Bechard, but also includes assignments (given orally if the participants can't write) about their personal experiences and such situations as the sentences they would impose for drunk driving if they were judges.

They consent to periodic checks through national, computerized police records. This is how Ms Bechard knows only 8% of the more than 250 graduates since April, 1983 have had subsequent criminal convictions.

In Chatham, senior probation and parole officer Denis Boileau was a pioneer in introducing such programs. A community committee worked out a four-week program for first offenders in 1978. If they asked to attend, their fine was reduced to $150. Attendance was a condition of a three-month probation.

The program has been revised to six sessions for all parolees and probationers with alcohol problems, covering family and workplace situations, handling stress, nutrition, and positive self-concepts.

No follow-up data have been compiled on effectiveness, but only three of the 400 attending have been sent back to court for failure to comply with the conditions.

NEWS

Removing chemical dependency exposes earlier griefs

Losses peculiar to women can impede recovery

By Harvey McConnell

WASHINGTON — Unacknowledged or incomplete grieving by women about issues exclusive to them can pose a serious threat to their recovery from chemical dependency.

The issues can range from loss of the role of wife, homemaker, and mother to the less obvious, but just as important, earlier loss of an infant through miscarriage, abortion, stillbirth, or early infant death. This is the view of Lorraine Hunt, PhD, of the Institute of Psychiatry and Human Behavior, University of Maryland School of Medicine, Baltimore.

Dr Hunt: "These are the kinds of deaths which are difficult for anybody to talk about. Most of us would like to think our society has gotten so enlightened there is no longer anything like shame around a miscarriage.

"That simply isn't true. Miscarriage, for example, is no more discussed in an open way now than it was 25 to 30 years ago. It is not a bad family secret, but it is not talked about enough."

She told the annual conference here of the Alcohol and Drug Problems Association of North America that the first three or four months into recovery is an emotionally turbulent time. It is not until the fourth or fifth month that clients start experiencing loss and grief.

"Grief is a deep and quiet emotion which can't be gotten in touch with in early months. But, eventually, women begin to think of all their losses in life," Dr Hunt continued.

Initially, they focus on the loss of the alcohol and other drugs they have given up. "It is the loss of a very dear friend for most of them. It was a friend who was always there, and there was a lot of comfort in that friendship. They depended on that friend very, very much, and now the friend is gone. It is a loss of which they are acutely aware."

Golobitsh

Learning to say good goodbyes: unfinished business needs to be finished

This is followed by thoughts of other losses, ones which were experienced but never acknowledged. These too need to be addressed in treatment.

Dr Hunt said the most obvious losses are the woman's role of wife and homemaker if the marriage has broken up, and the loss of the role of mother if the woman no longer has custody of her children.

Earlier losses have not been forgotten, even if they are old, and it is not difficult for the women to recall and review the details.

Dr Hunt talked recently with an 80-year-old woman who had had a miscarriage when she was 17 years old: "Within 10 minutes of talking to her, you would have thought it had happened yesterday."

Unresolved grief, combined with depression, can jeopardize recovery. Dr Hunt said the counsellor has no need to rationalize or explain: "Just sit with them as they remember back through what they lost."

At the same time, said Dr Hunt, "it must be remembered how forgotten men are in grieving about miscarriages. While attention tends to be focused on the woman, don't forget these babies who were never born also had fathers. In many cases, men have more trouble than women in acknowledging that kind of death."

Patricia Mysak, who works with Dr Hunt and who is on the faculty of the Rutgers Summer School of Alcohol Studies, New Jersey, said one of their aims is "to teach our clients to say good goodbyes."

Every loss is a goodbye and every goodbye is a little death that needs some sort of grieving. Ms Mysak: "The loss can be anything: a person, place, thing, a role, loss of good health, loss of a certain type of experience." Unfinished business needs to be finished.

A "good goodbye" does not eliminate grieving, but it does minimize the effects. It makes it easier to get through a situation, she added.

Many people believe that they have made a successful closure, a good goodbye in a given situation. They feel they have grieved and everything should be complete. Ms Mysak's experience, on the other hand, shows that for many people the experience keeps returning.

She continued: "It is very important to acknowledge that this is the end of what was, that the relationship or whatever, is at an end."

For example, "nobody enters a marriage expecting or wanting it to go bad. When a marriage cracks up, it is a broken dream, and there are lots of sharp pieces that fall to the floor. It is important to acknowledge the good parts of the dream that once was, and not to focus simply on the fact that the dream is broken."

In recovery from alcohol or other drug addiction, it is important to acknowledge the positive things the chemical did for people — it helped them to cope, it helped them to sleep, and they need to acknowledge that it was good for them at the time.

There needs to be an expression of regret for what did not or could not happen or what one would have liked to have seen happen. In death, for example, funerals act as a ritual celebration of what was, a blessing, even if it is painful. "We need to celebrate it so we can let it go," Ms Mysak added.

Stamping and stomping look good, but . . .

By Wayne Howell

When I was a child of 12 years or so, I started a fire to burn some autumn leaves. My fire was a roaring success, but the site I had selected for it was not. It was too close to some dry grass encroaching on a grove of maples. As the wind picked up, some flaming leaves went too, and before long I had a grass fire on my hands.

I started stomping and stamping for all I was worth. My main concern was that I get the fire put out before my parents returned and — please God — I wouldn't have to call the town volunteer fire department. They would come and put out the fire to be sure, but at the same time expose me as a bungling idiot. So I danced about in a frenzy. But, flames continued to spring up at one end of the line while I was at the other, and when I went to stamp out those, flames would appear where I had just been.

Eventually, when I had to admit to myself that I was slowly losing ground, I hit upon the idea of momentarily abandoning the fire to its own devices, running for the house, and drawing a pail of water. But that was a risky proposition: the fire could get really out of control while I was gone, and I had no assurance that one pail of water — or even two or three — would do the trick. And, if the bucket brigade failed, I would have to call the fire department and suffer the humiliating consequences, not the least of which would be the sight of all my friends arriving on their bicycles behind the fire department truck. So I soldiered on, preferring ineffectual activity to decisive — but potentially embarrassing — action.

Finally, when things got truly desperate, I took the gamble. It turned out to be an excellent one. With one pail of water, and some vigorous stamping on my part, the fire was extinguished. I was a hero in my own mind and remained so until I learned that a snoopy neighbor across the road had observed the whole thing and had reported it to my father. My father could not resist informing me that my belated intelligent act did not exculpate me from my initial stupidity.

I will be the first to admit that this memoir of juvenile incendiary activity is an imperfect metaphor for the problems of drug abuse, but bear with me for a moment — sometimes an imperfect metaphor is better than no metaphor at all.

Notwithstanding the best efforts of the DEA (Drug Enforcement Administration), the RCMP (Royal Canadian Mounted Police), and similar organizations, illicit drugs are widely available in North America; "stomping" in the country of origin and "stamping" at the border are, at best, marginally effective activities. Could it be otherwise, given the receptiveness of the ground? North Americans, be they baseball players or barrio dwellers, are more often than not dry grass waiting to be — demanding to be — lit up. Given this, interdiction is bound to be a fruitless activity, and statistics from interdicting agencies bear this out. Despite massive expenditures of public funds for *Miami Vice* shenanigans, interdicting agencies only apprehend a small percentage of the traffic in cocaine, heroin, hashish, etc.

In view of this, it is not surprising that addictions professionals are becoming more concerned with the "dry grass" than the opportunistic flames and, like Tamar Oppenheimer, director of the United Nations Division of Narcotic Drugs, are suggesting that if The First World could learn to control its appetite for consumption, The Third World would soon lose its proclivity for production. In other words, dampen down the grass — by means of research, education, and prevention at the community level — and the flames will get no hold.

As a fire-fighter from way back, I can appreciate that this is the only reasonable course. But, as a fire-fighter from way back, I can appreciate also that reason is not always, and not necessarily, part of the decision-making process. Remember that when my fire was inexorably moving out of control my main concern was one of image —what my parents would think, what the fire department would think, and what my friends would think. I kept on stomping and stamping long after I had realized I was doing no good, because as long as I was stomping and stamping at least I was looking good.

I would like to think our political leaders have a more mature outlook than a frightened kid fighting an ill-conceived fire. But, my readings of modern and not-so-modern history suggest to me that "the state," be it a democratically-authorized entity or an authoritarian monstrosity, ultimately comes to reflect our most juvenile hopes, dreams, and impulses. In the end, we get presidents that quote Rambo (Reagan), presidents that act out James Bond fantasies (Mitterrand), and general secretaries that posture like petulant czars (Gorbachev).

The hardest thing is to admit error, reverse direction, risk all, and run for the pail of water. It is easier to ignore reality and keep on stomping and stamping. You're spending your millions, or billions, and you're looking good doing it. And, if it is pointed out that you are not actually doing too well, then you can always respond with platitudes; you can always blame the citizenry for letting the sanctity of the family and a concern for community values fall by the wayside — blame the grass for being dry, in other words. (Everyone could have a family like Bill Cosby's if they really tried. How come dad isn't a doctor, how come mom isn't a lawyer, how come the kids aren't charming and precocious? It's just a matter of getting people to shape up.)

The platitudinous approach sure beats tax reform, welfare reform, and urban renewal —a heavy pail of water for governments to bear, an expensive pail of water for governments to bear, and most important of all, an embarrassing pail of water for governments to bear. That being the case, I predict that our governments will continue "looking good," by stamping and stomping, but will hedge their bets by picking up on recently-offered clues from the addictions fraternity and encouraging people to indulge in "moral aerobics." Do it North America, do it to the beat:

Family and community Yea Yea!
Family and community Yea Yea!
This concept is surely neat:
Coke and Smack, we've got you beat!

And, if some "community worker" has the temerity to suggest there is little family or community left — that, in fact, it looks like a jungle out there — then, fire the bastard. When you're concentrating on looking good, who needs that kind of negativism?

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor... Letters to the Editor...

Bandits promo hits kids

Tobacco pouch logo irks dad

Minister of Health and Welfare, Jake Epp is on record as favoring education rather than regulation of the tobacco industry.

A half a million Canadians have died from tobacco-related illnesses since the government, taking the education route, abandoned attempts to regulate the tobacco industry in 1971.


Epp

I hope Mr Epp intends to keep the message simple because it seems my seven-year-old son is the industry's latest target. When I went to a local store to buy him a Blue Jays' cap for his birthday, there were none to be found. However, I could get one in his size with a Skoal Bandits (a brand of smokeless tobacco) logo.

Now, wouldn't that make you spit?

Ronald M. Hart
Picton, Ont

Hat badges: enough to make a person spit

Tweed centre story boosts awareness

I would like to offer my very sincere thanks for the excellent story on The Jean Tweed Centre (July). We are most appreciative of Joan Hollobon's help in making our centre better known as a treatment option for women suffering from an addiction.


Davison

Again, thank you from all the professionals and individuals who are now better informed.

There is one error which I would like to point out. The number of cross-addicted women attending the centre is 80%, not 8%.

Heleni Davison
Corporate and Community Relations Manager
Jean Tweed Treatment Centre
Toronto, Ont

NZ writer on CoA

My son has been getting **The Journal** by subscription and has been passing it on to me.

I read with great interest your articles on families and alcohol (May, April, 1985; October, 1984).

Because I believe there is a colossal ignorance, here in New Zealand, of the damage done to spouses and children of alcoholics, I am at present doing a survey. I hope to have the findings published.

I would be quite happy for anything to be published about this project and have attached a survey.

W. P. Butler
Nelson, New Zealand

(Ed note: Readers wishing to reply to Mrs Butler's survey on familial alcoholism may write to **The Journal** *for both a copy of the questionnaire and a mailing address.)*

Roanoke Valley welcomes TJ

Our agency has been so pleased with your publication that we would like to place an order for an additional subscription.

Janice A. Matz
Administrative Assistant
Roanoke Valley Alcohol Safety Action Program
Salem, Va

Philippine drug command finds TJ info valuable

On behalf of the officers and men of Narcotics Command, we wish to extend our appreciation for the valuable print materials which your office provided for us.

We believe these materials will contribute immeasurably to our efforts to enhance operational efficiency and effectiveness of this command.

Please include this Command on your mailing list.

Ramon E. Montano
Brigadier General, AFP
Commanding General
Narcotics Command
Quezon City, Phillppines

Values program sparks interest

We would like more information about the program called Values, Influences, and Peers (January).

Please forward this letter to Jack Davis, Education Officer, Ontario Ministry of Education, or send me Mr Davis' full address so that I may write him directly.

Mary Muir
Director
Danny Fisher Centre
Kindersley, Sask

(Ed note: Your letter has been forwarded to Mr Davis.)

Reprinted from **The Journal**, *August, 1980*

The Journal *welcomes Letters to the Editor. Letters bearing the full name and address of sender may be sent to:* The Journal, *33 Russell St, Toronto, Canada M5S 2S1.*

Beer and Wine in Grocery Stores

The Implications

The area of public policy on alcohol control and availability, as is reflected again and again in The Journal, is characterized by dilemma and conflict. Alcohol use means different things to different people and groups. While social and health costs are recognized, so too are some benefits — to good fellowship, to tourism, employment, and the economy.

As individuals, groups, and the government in Ontario grapple with the question of allowing sales of beer and wine in grocery stores, and of what it might mean and to whom, The Journal publishes a document prepared by scientists at the Addiction Research Foundation (ARF). It examines the implications of such a move from a public health perspective, and not from an individual, economic, or political perspective, which are beyond the ARF's mandate. — The Editor

Summary Statement

Research at the Addiction Research Foundation (ARF) strongly indicates that the proposed sale of beer and wine in grocery stores would have an important negative impact on public health in Ontario.

Over the past decades, drinking has become more and more socially accepted, and there are undeniably economic and fiscal benefits that derive from the widespread use of alcoholic beverages. At the same time, alcohol use represents a major public health problem. The probability and severity of adverse health effects in people, particularly liver cirrhosis and cancer of the digestive tract, is strongly related to levels of alcohol intake. High alcohol intake is also strongly related to social consequences such as drunk-driving injuries, industrial absenteeism, poor productivity, and domestic violence. Approximately half of all traffic fatalities and one of every 10 deaths overall in Canada is related directly or indirectly to alcohol use.

Further, levels of alcohol problems are closely related to mean levels of consumption in society, which are in turn influenced strongly by availability. In general, research has found that relaxations of restrictions on alcohol availability result in increased consumption and, as a consequence, in increases in levels of alcohol-related health and social problems.

The recent history of Ontario serves as a case in point. When the age of majority was lowered to 18 years in 1971, what followed was unanticipated increases in traffic injuries and fatalities among teenagers as well as marked increases in alcohol abuse in secondary schools. As a result, the government raised the drinking age to 19 years in 1978. In this and similar experiences elsewhere, the short-term benefits of a liberalization measure were easily identified but the long-term complications were less clear. Fortunately, it was possible to reverse the policy when the disadvantages of the original decision to relax restrictions became evident. The same may not be true with respect to the sale of beer and wine in grocery stores: once thousands of retailers are economically dependent on alcohol sales, it may not prove possible to reverse the policy regardless of consequences.

Once again, there is pressure to relax restrictions on the availability of alcohol. The proposal has been put forward to permit beer and wine to be sold in grocery stores. Although there would be some problems for retailers, such as civil liabilities for selling alcohol to underage or intoxicated people or the possible need to bar underage employees, the proposed change would undoubtedly benefit some grocers. However, the proposed change would also have a marked impact on the health and social problems associated with alcohol use. This change would dramatically increase the number of outlets, which in itself would increase levels of alcohol consumption. It would also have symbolic implications and represent a further shift from treating alcohol as a special substance subject to special controls to treating it as an ordinary commodity like soft drinks.

In 1981, a study group at the ARF analyzed the likely impact of a proposal to permit the sale of beer and wine in a limited number of stores (1,700 new outlets). It was projected that even this proposal would substantially increase per capita consumption of alcohol by 0.6% to 3.2%, which in turn would increase the number of people consuming alcohol at levels associated with alcoholism by 1.2% to 6.5%. This represents an increase of between 2,650 and 14,260 people. There is little doubt that the impact of the current proposal would similarly entail a major increase in the number of people consuming very high levels of alcohol.

Therefore, it is recommended that before any change is made, all the ramifications of the decision be considered. It is doubtful whether increased access to alcohol is really needed. A small number of people would benefit, but the change would also entail considerable costs and public health consequences to the general population. Given the historical experience of Ontario and given the findings of research on the connection between alcohol availability and alcohol problems, it must be concluded that, from a public health perspective, it would be against the best interests of the people of Ontario to permit the sale of beer and wine in grocery stores.

Background

In the early 1970s, the decision was made to lower the age of majority, and with it the legal drinking age, from 21 years to 18 years. With regard to the drinking age, various political and social justifications were offered, such as fostering sophisticated and cosmopolitan drinking patterns, reducing paternalism by the state, supporting local industries, and discouraging illicit drug use. Almost 15 years have passed since the most recent major relaxation of Ontario's liquor laws; however, within a few years of that decision in 1971, it became evident that there was, as usual, a price to pay for easing access to alcoholic beverages. In this case, the price was increased morbidity and mortality around motor vehicle accidents involving young people and an increase in alcohol problems in secondary schools. Despite the research data indicating higher consumption and elevated rates of alcohol-related motor vehicle accidents for the age group affected by the change, it was possible for policymakers to orchestrate a reversal of only one year: in 1978, the Ontario government raised the drinking age to 19 years. Ontario is not alone in its experience. In several states in the United States, the drinking age has been rolled back to 21 years with dramatic, positive effects on rates of motor vehicle accidents among young people.

There are several important lessons that should be drawn from this experience. It appears that the immediate and general benefits of lowering the age of majority from 21 years to 18 years were relatively easy to identify and therefore given primary importance, whereas complications of the lower drinking age, such as increased health hazards, traffic injury and death, and unanticipated problems of alcohol use in secondary schools, were difficult to estimate and not given as much weight. But, the long-run implications of incremental changes in availability are rarely foreseen or considered. These include the transformation of the drinking climate and mores, the acceptability of drinking and drunkenness among youth, and a reduction in the percentage of abstainers. The system and method of decision-making on matters of access to alcohol do not fully take into account the complications and hazards. Also, as was seen in the middle to late 1970s, it is difficult to reverse a policy decision when the initial change involves increased access to alcoholic beverages.

The substantive issue in 1985 is different from that of 1972: today, the issue is that of increased "geographic" accessibility and the privatization of the industry; in the early 1970s, the question was whether "demographic" accessibility would be extended. However, it should be clear that the lessons from the 1971 experience have a bearing on the changes under consideration today.

Significance of the Proposed Change

Allowing the sale of wine and beer in grocery outlets is significant for several reasons:

1. It would involve a dramatic increase in the network of off-premise outlets. For example, if 1,700 grocery outlets were allowed to sell wine and beer — as was proposed to the Ontario cabinet in July 1979 — they would add to the package store outlet system by more than 200%.

2. The change would be a major step toward privatization of the alcoholic beverage distribution system. Currently, there are three components to the off-premise distribution system: the government-run Liquor Control Board of Ontario stores and agencies, the Brewers' Retail stores managed by the Brewers' Warehousing Company Ltd, and retail kiosks and stores of Ontario wine companies. The proposed arrangement would involve numerous, private, licensed agents, and result in reporting and regulatory arrangements that are much more complicated than is currently the case.

3. The proposed change involves a partial transition of beverage alcohol from the specialty shop to the general store. There are a number of implications; however, the most important is that the special status of alcoholic beverages is eroded, and the association with foods, sundries, and everyday routines is enhanced. To young people and adults alike, one message is that decisions to purchase this drug are no more significant than decisions to purchase gum, newspapers, milk, cereal, light bulbs, or bread. Another message is that beer and wine are alcoholic beverages of moderation; in fact, there are no alcoholic beverages of moderation, only moderate drinking patterns and moderate drinkers.

4. Finally, it is not clear that there is a significant public demand for changes in this direction, although one can see why the interests of wine and beer producers on the one hand, and grocery outlet owners on the other, would be complementary. Ontario government surveys indicate a fairly even split between those for and against increased access to alcoholic beverages, and typically a high proportion of "I don't know" or "no answer" responses. However, those in favor of increased access are not a typical cross-section of the adult population in that heavier drinkers are overrepresented among them. In other words, if there is a logical interest group in the general population, it appears that it can be found among heavier drinkers, who do not now have trouble getting more than their share of the product and will not improve their health status by drinking more.

One interpretation of the current situation is that a proposal to increase dramatically access to beverage alcohol by promoting privatization is being given serious consideration without there being either a strong public demand for the change, a demonstrated consumer need, or a public awareness of its public health implications.

Implications

The size of the expansion of the outlet network and the qualitative shift in the selling venue are major implications of this change. In the Ontario context, the change would likely set a precedent for elaboration along the lines of, for example, eventually adding spirits as well, replacing government-controlled outlets with private ones, and further expanding the networks of outlets once a number of grocery stores have a licence. In addition, there may be pressures to increase the hours of sale, lower the price of products, and increase the opportunity for impulse buying. Also, there will be easier access to alcohol for juveniles. With liquor sold in other than controlled outlets,

(continued from page 7)

likely there will be increased legitimation of regular drinking.

But, some of these implications are farther down the road, possibly for another generation to deal with. What about the more immediate implications? There is very little doubt that beverage alcohol consumption will increase disproportionately in relation to current trends. From the view of the producer and distributor, there would be no justification for bearing the cost of increased shipping if this cost will not be offset by increased sales. Increased tax revenue to the government is also expected and probably a salient consideration.

While it is reasonable to conclude that there will be an increase in sales, it is not clear how large the increase will be. In the early 1980s, a study group's report to the ARF president provided low, medium, and high estimates. The first two estimates were based on a proposal to the Ontario Cabinet and an estimate by the chairman of the Wine Council of Ontario, respectively. The high estimate was an extrapolation from an increase in Ontario wine sales following expansion of winery outlets between 1977 and 1979 (from 62 to 123 outlets). Assuming that there would be 1,700 new outlets (proposal to Cabinet, 1979), the study group estimated the aggregate sales in the first full year, the average sales of Ontario wine per grocery store, and the increase in per adult sales. These figures are presented in the table at right.

Even relatively minor changes in the rate of consumption, such as an increase of a percentage point (or less), will place a large number of people into high-risk categories. This increase alone should be ample reason for caution in considering relaxing access to alcohol. However, in addition to risks to drinkers and higher rates of dependence, other complications need to be weighed. Motor vehicle accidents involving alcohol; accidents in the home, workplace, or public domain; violence; public disruption; and, the main chronic ailments related to heavy alcohol intake need to be considered in assessing alcohol policy proposals.

Indicating that there is a profit to be made for the average grocery store owner is not as difficult as estimating what problems will follow and what their magnitude will be. It is clear that average sales of about 60 bottles of wine per day per store (high estimate for 1979 figures) would substantially increase the gross income of a small business. Even a 50-cent profit per bottle would create an annual income of about $9,000. However, would this benefit compensate for problems and liabilities facing the store owners and staff? With regard to the latter, one can envisage incidents of those in charge of a small family-run store being intimidated by underage or intoxicated customers who should be denied service. Not only is serving underage or intoxicated customers a breach of the Liquor Licence Act, but it may also lead to a civil or criminal suit against the store if violence or an accident follows the inappropriate sale of alcohol. With more outlets, there is an expanded need to instruct staff in handling volatile situations, and greater risk of complications with customers and possible lawsuits. These developments could lead to higher insurance premiums for store owners.

Research on Availability, Consumption, and Consequences

A significant body of research has a bearing on the policy proposal under consideration. What has been labelled the "control" or "availability" perspective in alcohol sociology and epidemiology has links to developments in public health research, and to recent initiatives in preventing or reducing alcohol problems through interventions oriented to the buying and consuming environment. The following generalizations can be drawn from the extensive body of literature that is developing in this area:

1. Increases in access to alcohol are likely to facilitate a higher rate of consumption; conversely, decreases in access are likely to reduce consumption. The evidence in support of this point is from "natural experiments" where dramatic increases or decreases have occurred, as well as from correlational studies.

2. The relationship between access and consumption is not a simple uni-directional one. Cultural changes in such areas as leisure time, consumers' behavior, and alternative applications of discretionary dollars mediate the relationship between availability and consumption. For this reason, longitudinal studies that examine the experiences in one jurisdiction over time are of greater utility than cross-sectional studies that compare and contrast jurisdictions at one point in time. However, if findings from longitudinal research have greater validity, they still do not fully resolve the methodological and conceptual problems of drawing from the experiences in a jurisdiction other than the one under consideration.

3. Not all changes in availability have a similar potential for raising or lowering the rate of consumption. Measures that influence the "real" price are considered to have the greatest impact. The findings on this topic are strong and consistent: high "real" price is correlated with low consumption, and low "real" price with high consumption. Both cross-sectional and longitudinal data support this conclusion. Other aspects of access to alcohol do not offer as consistent a relationship with the rate of consumption.

These generalizations hold for rate of outlets. However, when outlets are differentiated into "on-premise" (restaurants and bars, etc) and "off-premise" (liquor, beer, and wine stores), the better-designed studies, particularly of off-premise outlets, suggest a positive correlation with the rate of consumption. For example, areas with a higher rate of liquor stores tend to have a higher rate of sales.

A recent study examined four US states in which regulatory changes increased access to alcohol via sale of wine in grocery outlets. The author found that in three of the four states the consumption of wine for the year of the change was significantly greater than one would have expected from trends in consumption before the change.

In contrast to the situations in other jurisdictions, the experience in Quebec in the late 1970s was that the increase in consumption was not as large as would be expected. In 1978, Bill 21 provided an increase in the number of off-premise wine outlets from 353 to more than 9,000; an extension of the hours of sale (by an average of four hours per day and sales on Sunday); and, wine sales in rural areas where there were few government retail outlets. A study found that aside from an 18.5% increase in wine consumption for the first year (from 1.6 to 1.9 litres of absolute alcohol per person aged 15 years and older), few other dramatic changes were evident. However, some of the rural areas of the province experienced a sizable increase in drunk-driving offences following the enactment of Bill 21: for instance, a 46.9% increase in the Northwest region and 26% in the New Quebec region.

Strictly speaking, the Quebec experience cannot be transferred to the Ontario context. In addition to general cultural differences in drinking style and uses of alcohol, there are specific aspects of the increased access to alcohol that were peculiar to Quebec. First, the implementation of the new policy overlapped with a workers' strike at the government liquor stores, so that initial sales of wine at the grocery stores were likely substitutive rather than additive. Second, the majority of the outlets already had long-standing permission to sell beer; the change did not add a new alcohol distribution network but added a new class of beverages to an existing network. Third, one of the key purposes of Bill 21 was to encourage the sale of Quebec Liquor Board (SAQ) products. On this point, the volume of SAQ house wines and wines produced in Quebec increased sharply between the 1977/78 and 1979/80 fiscal years, whereas the sale of imported wine declined for the 1979/80 (-33%) and 1980/81 (-21%) fiscal years. Fourth, the changes implemented with Bill 21 coincided with an economic recession, which likely deflated the potential for increased access to stimulate alcohol sales. Although we are not in a boom period, the economic climate in Ontario in the mid-1980s is probably more stable than that of Quebec in the late 1970s.

The study group that reported to the ARF president in 1981 drew several conclusions about the outlet availability issue. It would appear that their conclusions still apply, and are therefore quoted verbatim:

"While there is no clear evidence that every increase in outlet availability will lead to an increase in per capita consumption, the study group is persuaded, that under certain conditions, increased availability (through outlet expansion) encourages the consumption of beverage alcohol.

These conditions, all of which apply to the proposed change in the availability of Ontario wine, are the following:

1. An increase in the number of off-premise outlets is more likely to have an impact than is an increase in the number of on-premise outlets. Typically, alcohol is less expensive in off-premise outlets, and the volume per outlet is considerably higher than in the on-premise network.

2. A sudden, massive change in the number of outlets is more likely to have a measurable impact than small-scale incremental changes.

3. An increase in availability is likely to have a greater impact if the change occurs in a dry rather than a wet environment. Ontario has a lower rate for off-premise outlets than adjacent jurisdictions and could be considered to fall into this category.

4. Beverages with a relatively small share of the market are more likely to respond to increased availability than are beverages with a large share. Ontario has a low per capita level of wine consumption when compared to the other beverage types within the province, and thus wine is clearly a beverage whose share of the market is small.

5. Research on elasticities by beverage type suggests that a more elastic beverage, as is Ontario wine, may be particularly responsive to increased availability."

Estimated Impact of Proposed Changes in Domestic Wine Distribution in Ontario

(Based on 1979 data and 1,700 grocery outlets with licences to sell Ontario non-fortified wine)

Level of Estimate	Increase in aggregate sales (litres of absolute alcohol)	750 mL bottles per store per selling day	Increase in per adult rate of consumption	Increase in proportion of heavy drinkers*	Increase in number of heavy drinkers
High	2,407,049	60.3	+ 3.2% (11.52-11.89)	+ 6.4%	+ 14,260
Medium	871,454	21.8	+ 1.2% (11.52-11.65)	+ 2.2%	+ 4,750
Low	454,600	11.4	+ 0.6% (11.52-11.59)	+ 1.2%	+ 2,650

* The base used in estimates of heavy drinkers was 220,320 people drinking absolute alcohol 14.7 cL/day average or greater. It was estimated that 4.17% of the drinking population was consuming at this level.

Conclusions

A number of questions can of course be raised about the research to date and the relevance of specific experiences elsewhere to a proposal that has direct bearing on the population of Ontario. One should consider the following basic questions:

- **Does the population of Ontario need increased access to alcohol?**
- **Which groups or sectors of the Ontario society desire this change?**
- **Who will benefit from providing wine and beer in grocery stores?**
- **Who will experience setbacks, complications, and public health or public order complications as a result of this policy change?**

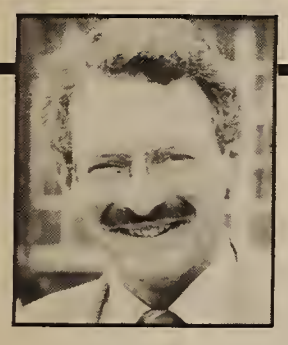
The post-war developments in access to alcohol in Ontario and concomitant changes in rates of consumption and damage do not lead to the conclusion that increased access is warranted and desirable. Indeed, a case can be made for the opposite viewpoint — namely, that more stringent regulation would be of benefit to public health. While certain groups desire the change and will reap economic benefits from it, there is little reason to believe that the public will benefit, and the complications will eventually be borne by all sectors of society, particularly by the heavy consumers and other victims of alcohol-related incidents and ailments.

The liquor laws, regulatory system, and policy development procedures of the province should be reviewed from time to time. The purpose of such a review should *not* be to make the system more relevant to current social whim or to ease frustrations related to temporary disruptions in the distribution system, but rather to:

- determine if current laws are effectively enforced;
- assess whether the regulatory system takes into account the experiences of increased consumption and damage; and,
- consider whether the procedures for policy development represent views that are in line with public health implications of increasing alcohol consumption.

Reference material for the Addiction Research Foundation statement ***Beer and Wine in Grocery Stores — The Implications*** *is available from* The Journal.

COMMENT



GILBERT

'... allowing the sale of wine and beer in grocery stores could lead to a reduction in overall levels of alcohol consumption and a consequent reduction in public health problems associated with alcohol use'

Beer, wine, and groceries

By Richard Gilbert

Many members of the Progressive Conservative and New Democratic parties in Ontario firmly believe that the Liberals did so well in the May election (eventually forming the government with the help of the New Democrats) because their leader advocated the sale of beer and wine in small grocery stores at a critical point in the campaign.

As a candidate in that election, who failed by a wide margin to unseat a Liberal incumbent, I can attest to the popularity of the proposal, at least among younger voters.

Liberalizing the sale of beer and wine in this way was said to provide many benefits:

1. It would provide a boost to certain small businesses that are flagging on account of economic hard times worsened by stiff competition from supermarket chains.

2. The increased number of outlets would be more convenient for consumers. The wider range of hours of sale would complement the growing variety of patterns of daily living in our society.

3. It would be a symbol of a more relaxed and potentially healthier attitude to alcoholic beverages.

4. Government regulation would be loosened, in that the government-approved monopolies on the sale of beer and wine for off-premise consumption would cease. Liberalization was presented as a desirable form of privatization.

No hurry

The Liberal government of Ontario does not appear to be in a hurry to implement its leader's proposal, even though it may have been a powerful contributor to the outcome of the election. The proposal has not been given such high priority as abolishing extra-billing by physicians, controlling toxic spills, and cleaning up government advertising contracts. This minority government may also be concerned that the measure would fail in the legislature. Both opposition parties appear to be against the proposal.

New Democrats are against selling alcohol in corner stores because they share the values of the union movement, which is concerned about the loss of unionized jobs. There are, no doubt, strong anti-union sentiments behind the proposal, fueled by beer shortages during a strike early this year.

Also, temperance strains run strong among New Democrats. The present leader lives close to Ontario's only dry area, which stays that way because of the amazing persistence of octogenarian William Temple, who remains a major force in the party (**The Journal**, June, 1984).

(But, I should mention too that the last time the matter was raised in the Ontario legislature was by the maverick NDP member, George Samis, now retired. His 1980 private member's bill did not proceed beyond first reading. Mr Samis received a lot of criticism from brewery workers at the 1981 convention of New Democrats. He did not raise the matter again.)

Progressive Conservatives have never shied before from loosening Ontario's alcohol laws. Their 42-year-long reign in Ontario, terminated abruptly in May this year, was characterized by remarkable bursts of relaxation. Mr Temple can still hardly believe his eyes when he sees diners tippling wine and beer while sitting with their children on the patios of boulevard cafes located in residential neighborhoods.

The Progressive Conservatives' opposition to corner store sales appeared at first to be a knee-jerk reaction to a Liberal proposal. More likely, it flowed from the long-standing, close association with Ontario's brewers, particularly the John Labatt family of companies. Edward Stewart — the senior provincial bureaucrat during the final years of the Progressive Conservative reign and a rare partisan among Ontario's top civil servants — is now executive vice-president of Labatt Brewing. Edwin Goodman, a long-time senior strategist for the Progressive Conservatives, is a Labatt director.

Ontario's brewers are opposed to selling beer in corner stores. It would detract from their virtual monopoly to sell their product in what are known as Brewers' Retail Stores. These 445 stores throughout the settled parts of Ontario are run by the Brewers' Warehousing Company Limited. This company is owned by the five major Ontario brewers. It was established in 1927 with the cooperation of the provincial government to manage the end of prohibition.

The Progressive Conservatives have appeared uncomfortable in their opposition to selling alcoholic beverages in corner stores. It flies in the face of ideals they are supposed to espouse: private enterprise and an unrestricted marketplace. How could they both be the champions of small business and oppose something that might generate a lot of sales for corner stores?

Richard Davidson, president of Brewers' Warehousing, gave the Progressive Conservatives a much appreciated escape route when he met with legislature member Robert Runciman in August. Mr Runciman is the party spokesman on consumer and commercial affairs. Mr Davidson said that if the legislature approved the sale of beer in corner grocery stores, Brewers' Warehousing would be seeking to sell groceries and other items in their formidably efficient and well-located Brewers' Retail stores. Such a move could put thousands of independent grocers out of business, whether or not they sold beer and wine. No politician would ever want to be accused of being so stupid as to kill off small business in the guise of helping it.

Lost in all of this are some major considerations. Would corner stores actually benefit from selling alcoholic beverages, even if Brewers' Retail stores were kept out of the grocery business? Would consumers benefit to the extent that the increased convenience would more than compensate for the inevitable increases in average price? Would society benefit from the resulting change in alcohol consumption habits? Let me deal with each of these in turn.

Regrettably, in answering these questions I have few data to appeal to and almost no data that allow clear conclusions, except on the matter of price.

We cannot tell, for example, if corner stores, on average, will benefit. Would the increased business from the sale of beer and wine more than compensate for the costs? These include increased insurance to cover the new inventory and greater risk of break in, and increased payments for labor because people younger than 19 years could not be employed in the stores.

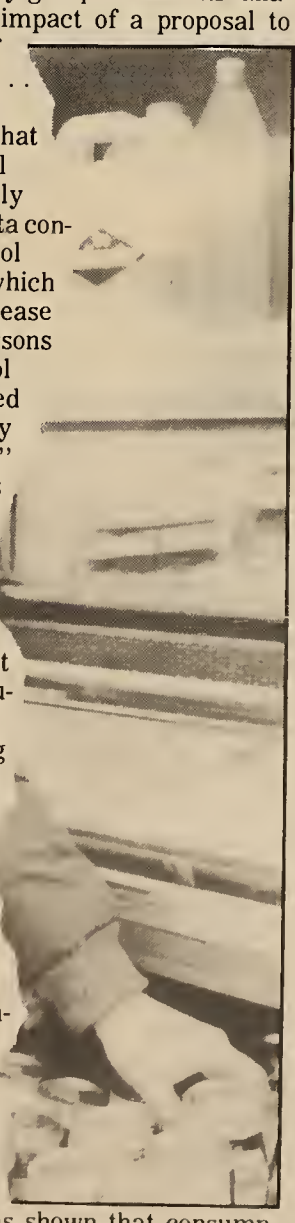
We do know that consumers will suffer in certain ways. Prices will surely increase to cover the additional costs of distribution and storage. Brewers' Warehousing estimates a $2-per-case increase, meaning that the retail price of Ontario's beer would no longer be the lowest in Canada. Beer deteriorates with surprising rapidity. The poor inventory control of the typical corner store would likely mean longer storage of beer under less than optimum conditions, and thus a general deterioration in the quality of the product as sold.

Concerning the overall cost or benefit to society, we have the position of the Addiction Research Foundation (ARF), set out in a Best Advice statement (see pages 7,8). The first paragraph is as follows:

"Research at the ARF strongly indicates that the proposed sale of beer and wine in grocery stores would have an important negative impact on public health in Ontario."

The research referred to is mentioned in a later paragraph:

"In 1981, a study group at the ARF analyzed the likely impact of a proposal to permit the sale of beer and wine in . . . 1,700 new outlets. It was projected that even this proposal would substantially increase per capita consumption of alcohol by 0.6% to 3.2%, which in turn would increase the number of persons consuming alcohol at levels associated with alcoholism by 1.2% to 6.5% . . . ."



In my view, this statement is misleading for the following reasons:

1. There is no ARF research that allows firm conclusions about the impact of allowing the sale of beer and wine in grocery stores on public health in Ontario.

2. The statement was wrong to indicate that the 1981 study concerned the impact of a proposal to liberalize the sale of beer. It was concerned with wine alone. Research in Scandinavia has shown that consumption of beverages with a relatively small share of the market is more likely to go up with increases in the number of outlets, than consumption of beverages with a large share of the market. A study based on wine, which has a relatively small share of the Ontario market for alcoholic beverages, could exaggerate likely effects on alcohol consumption if it were applied to beer, which has almost half the Ontario market. Thus, the 1981 study, the only one conducted at the ARF on the subject, is not particularly relevant and its use in the statement is misleading.

3. The statement did not mention that the 1981 study was based on a very doubtful assumption — that all of the sales of wine in grocery stores would be in addition to other alcohol consumption, rather than replacing at least some of it.

4. The statement did not mention that no consideration was given in the 1981 study to the possibility that the major consumption-related impact of allowing wine sales in grocery stores would be an overall increase in the average cost of off-premise alcohol. This could result in an overall decline in alcohol consumption, given the firm body of evidence that price and consumption are inversely related. The price differential for beer could be even higher than for wine. At the $2-per-case differential mentioned by the president of Brewers' Warehousing, beer prices would be on average 13.4% higher in grocery stores than in Brewers' Retail stores. The resulting decline in alcohol use might very well offset any increase in consumption that would result from increased availability.

5. The statement ignored the potential impact on consumption of having small rather than large quantities of beer or wine in the home. Beer, in particular, might be bought in smaller quantities from corner stores than from Brewers' Retail stores, both because of the higher price and because the bottles would be carried rather than transported home by car. Smaller quantities at home could very well be related to lower levels of consumption.

In my view, there is good reason to believe, particularly for the fourth and fifth of the points just made, that allowing the sale of wine and beer in grocery stores could lead to a reduction in overall levels of alcohol consumption and a consequent reduction in public health problems associated with alcohol use. This does not mean that the ARF or I should support the proposal to liberalize the sale of beer and wine.

Opposed

I remain opposed to selling beer and wine in corner stores, particularly beer, for the following reasons:

1. It would probably lead to an increase in sales to people younger than 19 years. Corner grocery stores are notoriously bad at obeying the law covering the sale of cigarettes to people younger than 16 years. There is no reason to believe they would do better with alcohol. The problem of sales of beer to underage people is immense. Nearly 400,000 would-be purchasers were challenged in Brewers' Retail stores in 1984 on the grounds they might be underage. Service was refused to about half of them.

2. Brewers' Retail encourages and facilitates the return of empty bottles (98% returned) and cans (75% returned) in a way that would simply not be possible if grocery stores sold beer. The cumulative impact on the environment would be considerable.

3. Corner stores selling alcohol, with their more valuable inventory and larger cash receipts, would attract break-in artists and increase neighborhood crime.

There is one way to increase the number of sales outlets for off-premise consumption that causes none of these problems. It is to allow such sales from bars, hotels, and other places licensed for on-premise consumption. This kind of arrangement exists in many countries, including Britain, where pubs often have "off-licence" stores attached to them. British Columbia recently granted hotels and pubs the right to open stores to sell BC wine, beer, and cider (**The Journal**, September).

Brewers and brewery workers appear to support the idea of selling beer and wine for off-premise use from licensed premises.

Even the ARF could find reason to get behind this idea if it meant reduced overall consumption of alcoholic beverages — which could happen if prices for off-premise sales were kept high, as high as prices for on-premise sales.

INTERNATIONAL

National study fuels pot law debate in Austria

By Gamini Seneviratne

VIENNA — First results of a comprehensive, country-wide scrutiny into cannabis use in Austria indicates 30% of those in the 18- to 40-year-old bracket have "experienced" the drug — most out of curiosity, and only a few times.

The survey, financed by the federal ministry of health and environmental protection, began in September, 1984 and is due to be completed by the end of the year. It is being conducted by the Boltzmann Institute for Addiction Research, one of a cluster of some 60 specialist bodies named after the late Austrian physicist.

The broad consumption figures, based on a questionnaire answered by 2,000 men and women in the age group, are now being analyzed. They constitute part one of a two-part research program. The second section involves long, detailed interviews with individuals.

The interviewees — numbering at least 120 — have been randomly selected from specific groups: regular consumers who have not had an encounter with the law, regular consumers who have, members of youth organizations including some affiliated with the church, staff members of health facilities, etc.

The probe goes beyond consumption patterns and reasons into such areas as the interviewee's appreciation of the psycho-physical impact of regular consumption, comprehension of the law on the substance, and interactive attitudes of society and law enforcement in the country.

The research is being conducted against the background of a mild, but continuous, debate on a fine line of argument between decriminalization and legalization of cannabis. The debate was set off by evidence at a mid-1984 trial of a man charged with possessing four kilograms of hashish.

The burden of the defence plea — that hashish was not a dangerous substance — was extraneous to the statutes; but the testimonies of experts summoned by defence and prosecution differed only on the degree of its innocuity.

Extensive media coverage prompted Kurt Steyrer, federal minister for health and environmental protection, to elucidate official sympathy for decriminalization. This was interpreted by some to mean legalization.

The seemingly-strengthened *ad hoc* lobby for the latter course has consolidated around a group called *InHale*, with a small office here and a still-embryonic country-wide campaign. Its members introduce themselves only by first name and are circumspect about answering the telephone.

The campaign itself is legal. An independent lawyer says: "Promoting cannabis smoking is illegal but promoting legalization of smoking is legal." Both the police and *InHale* seem to be somewhat less than confident, however, and confrontations on the street are frequent but inconclusive.

Austrian law makes it an offence to promote the use of any drug covered by the Single Convention on Narcotic Drugs, 1961, and the 1972 Protocol by publication, picture, film, or in any other way. Sooner, rather than later, *InHale's* campaign will be tested in courts.

Meanwhile, Mr Steyrer's advocacy of decriminalization is no more than an extension of the country's newly-amended drug law (**The Journal**, June). Compassion for the dilettante drug user is a key component of the law and has been since the earlier (1981) amendment, which gave statutory authority to the therapy-comes-before-punishment attitude.

In the past few years, federal and state authorities have spent an estimated extra 30 to 35 million schillings (Cdn $1.8 million) to lift treatment and care facilities to the current "satisfactory" plateau.

There are now 150 beds exclusively for dependents on "illegal" drugs (excluding alcohol and prescription drugs) in four specialized treatment centres. Additional in-patient care is available in some 30 other drug centres geared more to out-patients. Many regular hospitals now have clinics to provide medical, as opposed to psychiatric, aid to drug patients.

A noteworthy innovation is the introduction of street workers into the health cadre. One Vienna facility has seven people providing counsel and care on location and among groups most vulnerable to drugs. Many other centres have at least one street worker.

On cannabis, specifically, the Austrian attitude toward the user is much like the Swiss — that minor delinquencies against the statute should be treated more as badgatelles than crimes, earning warnings rather than punishment.

Ingried Erlacher, a senior official at the federal ministry of health and environmental protection, says Austrian society looks in three directions on cannabis. "One sees severe punishment of user and dealer alike as the only response. You must understand that most Austrians do not see any difference between cannabis and, say, cocaine and heroin.

"At the other extreme, a very small section wants complete liberalization of consumption as well as distribution. The third group discriminates between the curious, the dabbler, the dependent, and the dealer, even between the amateur and professional dealer." The minister of health and environment is very much in this camp.

What Mr Steyrer means by decriminalization, explains Dr Erlacher, "is that the official response to cannabis use, as distinct from professional dealing, must be as compassionate as it is firm. We should not put a mark of criminality on every first-time user, particularly young people, and jeopardize their future. That cannot help drug abuse control."

Salzburg: Austrian society looks in three directions at once on cannabis issue

New Zealand liquor industry study

Alcohol costs are 'overrated'

By Pat McCarthy

AUCKLAND, NZ — Challenging traditional views, an economist here questions whether the cost of alcohol abuse to society is as great as is usually claimed.

In a study commissioned by New Zealand's liquor industry, Alan Woodfield, senior lecturer in economics at Canterbury University, Christchurch, says society does not necessarily feel the effect of a decline in or end to an alcohol abuser's productive life.

In times of unemployment, there are others who benefit from the chance to work. With full employment — although there would be a reduction in national income — alcohol abusers would drop into lower-paid jobs.

He says alcohol abusers who lose their jobs because of poor work performance, or who die prematurely, absorb the major cost themselves in terms of lost earnings. Those who are hospitalized also lose income.

"In the main, the public is not substantially affected, at least in regard to lost production."

He questioned also whether society should worry about a decline in productivity by an alcohol abuser when it does not worry about others who leave jobs to raise families or to travel abroad.

Mr Woodfield was commissioned by the Liquor Industry Council here to examine research financed by the government-backed Alcoholic Liquor Advisory Council (ALAC).

While ALAC's research estimated that alcohol abuse cost New Zealand more than $900 million (Cdn $717 million) a year, Mr Woodfield concludes that the cost could not be attributed accurately, but could not be that high. ALAC's response is that the liquor industry is trying to defend the indefensible while ignoring the inestimable effects of alcoholism.

Mr Woodfield says people who get sick or die prematurely from alcohol-related illnesses don't necessarily place an extra charge on medical services because they may not need costly care later for age-related illness or disease.

"If people die prematurely because they smoke or drink, they do not incur medical costs later in life . . . . In a sense, drinking or smoking appear to perform — and this is a ridiculous argument — the socially useful task of preventing people from getting old and suffering age-related diseases, and hence becoming a health cost again."

Alcohol abusers in New Zealand, he adds, can choose to live recklessly because they have a safety net of subsidized services which promise them cheap or free medical care — and even compensation.

"A high subsidy on medical care is hardly an incentive for anybody to be more careful in the activities they engage in which could lead to poorer health somewhere along the line. That is as true for hang-gliding or motor-racing as it is for smoking cigarettes or drinking alcohol."

Mr Woodfield also argues against taxing alcohol to pay for the health costs associated with abuse. The vast majority of non-abusers, he says, are being taxed in a "punitive and unnecessary" manner, since reducing their alcohol consumption would have no appreciable impact on health costs.

"The appropriate policy is to internalize the costs of alcohol abuse to the alcohol abusers, by charging them or their health insurers, the full cost of alcohol-related medical care."

While he admits there would be practical problems, Mr Woodfield adds it could be worth considering a system under which drinks in bars would be tax-free at first, then taxed progressively higher as consumption continued.

Alcohol and other drug use in Canada

Manuella Adrian, head, statistical research program, Addiction Research Foundation, based Stats•facts on: Statistics on Alcohol and Drug Use in Canada and Other Countries, *Volumes 1 and 2 (from data available by September, 1984).*

Alcohol

How many Canadians drink?

A 1983 national Gallup poll shows 73% of Canadian adults aged 18 years and older have ever had "occasion to use alcoholic beverages such as liquor, wine, or beer" and are not total abstainers.

In Ontario in 1984, 84% of adults said they'd ever used alcohol, with 49% of users having five drinks or more at a single sitting, and 40% reporting becoming "high" or "tight."

How much do Canadians drink?

In 1982/83, Canadians consumed 208.3 million litres of absolute alcohol, which works out to 10.8 litres per person aged 15 years and older, or 12.2 drinks per week or two drinks per day per consumer.

About 50% of what Canadians drink is in the form of beer.

Where do Canadians drink the most?

In Ontario, it's Kenora; in Canada, it's the Yukon.

How much alcohol advertising is there?

In 1983, 9% of all advertising to which viewing, listening, or reading Canadians were exposed, as measured by time on radio and television and space in newspapers and magazines, was paid for by breweries, distilleries, and wineries.

Meanwhile, a 1981 Canadian Gallup survey reports 49% of adults favor banning all liquor advertising, while 66% favor an increase in government advertising on the dangers of drinking.

How much money do Canadians spend on alcohol?

In 1982/83, Canadians spent $6.9 billion for alcohol in retail stores, and another $2.9 billion for alcohol consumed in taverns, restaurants, and hotels (1982).

How much money does the government make on alcohol?

In 1982/83, Canadian federal and provincial government revenue derived directly from the control and sale of alcoholic beverages reached $3.2 billion, or 2.1% of all government revenue. If general retail sales taxes and federal taxes on producers and distributors are taken into account, Canadian government revenue rose to more than $4.2 billion.

In Ontario, direct government revenue reached $733 million, or 3.4% of all provincial government revenue.

What are the social costs of alcohol problems?

Alcohol-related social costs due to excess use of health care, reduced labor productivity, law enforcement, and social welfare reached $5.3 billion for Canada and $1.6 billion for Ontario in 1981.

How many alcoholics are there?

Based on liver cirrhosis deaths in Canada in 1981, there were an estimated 587,000 alcoholics, that is people whose alcohol consumption was sufficiently high to cause them physical damage.

How many Canadians contravene alcohol-related legislation?

In 1982, there were 326,901 liquor act offences and 289,874 people charged with criminal offences under the liquor control acts. The number of offences exceeds the number of people charged, as one person may have been charged on more than one occasion. Approximately 13% of Canadians charged were charged with more than one alcohol-related offence during the year.

Overall, on a per capita basis, the Northwest Territories had the highest rate of alcohol offences, while Nova Scotia had the highest rate of people charged under the liquor acts.

How many Canadians contravene alcohol-related traffic laws?

In 1982, alcohol-related traffic offences accounted for 63% of all traffic offences under the Criminal Code and for 91% of all people charged for traffic offences under the Criminal Code.

There were 167,312 alcohol-related traffic offences: 149,800 driving while impaired, and 17,512 failure or refusal to provide a breath sample. The 143,424 people charged with traffic offences included 132,023 for driving while impaired and 11,401 for failure or refusal to provide a breath sample for testing. Approximately 17% of Canadians charged were charged with more than one alcohol-related traffic offence during 1982, a threefold increase in recidivism since 1979.

Overall, the Yukon had the highest per capita rate of driving-while-impaired offences, while Prince Edward Island, Nova Scotia, and New Brunswick had the highest rates of offences for failure or refusal to provide a breath sample.

How much legal aid assistance is required for alcohol cases?

In 1978/79, there were 13,127 legal aid cases for drunk- and impaired-driving offences. This accounted for 9% of all legal aid cases.

How many Canadians were sent to jail for alcohol offences?

In 1981/82, there were 19,304 admissions for drinking and driving offences, or 19% of all admissions to provincial/territorial adult correctional facilities which hold prisoners sentenced to less than two years.

STATS·FACTS

Alcohol and other drug use in Canada

(continued from page 11)

How many divorces are due to alcohol?

In 1982, there were 1,425 divorces with "addiction to alcohol" given as the reason for marriage breakdown. This represents 4.7% of all divorces due to marriage breakdown, or 1.5% of all grounds for divorces.

How many Canadians receive disability pensions for alcohol problems?

In a one-month period in 1980, 1,734 beneficiaries received disability pensions for alcoholic psychosis, alcoholism, liver cirrhosis, and toxic effects of alcohol.

How many Canadians are treated for alcohol problems?

There were 44,021 cases in general hospitals of alcoholic psychosis, alcohol dependence syndrome, non-dependent abuse of alcohol, chronic liver disease and cirrhosis, and toxic effects of alcohol in 1980/81, and 3,788 cases in mental hospitals for alcoholic psychosis and alcohol dependence syndrome in 1981/82.

On a per capita basis, Alberta had the highest rate of such cases in general hospitals; Prince Edward Island had the highest rate of cases in mental and psychiatric hospitals.

How many Canadians die of alcohol problems?

In 1982, there were 3,063 deaths in Canada from alcoholic psychosis, alcohol dependence syndrome, non-dependent abuse of alcohol, chronic liver disease and cirrhosis, and toxic effects of alcohol.

On a per capita basis, the Yukon had the highest rate of alcohol-related deaths.

Combined data from seven provinces over the past decade show that of all drivers fatally injured in car accidents and who were tested for blood alcohol, some 60% had a positive blood alcohol concentration; one-third had twice the legal limit. Based on Ontario 1982 data, it is estimated that overall in Canada there were more than 900 drunk-driver fatalities and about 150 fatal accidents involving pedestrians who were alcohol-impaired or had been drinking.

There were also an estimated 30 fatal snowmobile collisions in which the drivers were impaired (1982/83).

There were 23 deaths in fires due to suspected impairment by alcohol, other drugs, or medication.

Finally, based on national data from 1961 to 1974, it was found that in 41% of all solved murders, alcohol had been ingested by the suspect or the victim.

Tobacco

How many Canadians smoke tobacco?

In 1981, 36% of the population more than 15 years of age smoked cigarettes, 33% smoked daily. Quebec reported the highest percentage of smokers in its population.

How much do Canadians smoke?

In 1981/82, Canadians smoked 72 billion cigarettes, or 10 cigarettes daily per person more than 15 years of age, or 28 cigarettes per smoker daily.

The Yukon, the Northwest Territories, and Alberta had the highest tobacco consumption per person.

How much money does the government make out of tobacco?

In 1982/83, total Canadian federal and provincial government revenue derived directly from tobacco sales amounted to $2.2 billion, or 1.4% of all government revenue. In Ontario, it was $428 million, or 2% of all government revenue.

Other drugs

How many legal drugs do Canadians take?

In any two-day period, one in two Canadians more than 15 years of age takes some kind of medication (1978/79).

The most popular, legal, psychoactive drug in Canada is codeine. In 1980, Canadians had the second highest per capita codeine consumption in the world.

In 1981, wholesale sales records indicate over-the-counter and prescription analgesics accounted for 53% of all psychoactive drugs sold to drug stores and hospital pharmacies, while narcotic analgesics accounted for 25%.

How many Canadians use stimulants?

Based on a 1984 Ontario household survey, 2.5% of adults aged 18 years and older said they used stimulants at least once in the previous 12 months. In terms of sales to drug stores and hospital pharmacies in 1981, psychostimulants accounted for 12% of all psychoactive drug sales.

How many Canadians use tranquillizers?

In a 1984 Ontario survey, 9.3% of all adults said they took tranquillizers at least once in the previous 12 months; sales of minor tranquillizers accounted for 12% of all psychoactive drug sales.

How many Canadians take sleeping pills?

Seven percent of adults said they took sleeping pills in the previous 12 months. Sales of non-barbiturate sedatives accounted for 8% of all psychoactive drug sales.

What is the most popular illegal drug in Canada?

Cannabis.

The reported number of cannabis users aged 18 years and older has doubled since 1976. In 1984, cannabis use "in the past 12 months" was reported by 11.2% of the adult population of Ontario; an estimated two million adult Canadians used it at least once during the year.

How many Canadians use cocaine?

In 1984, 3.3% of Ontario adults reported using cocaine at least once in their lifetimes. This would correspond to an estimated half a million adult Canadians.

Is there any other significant use of narcotic and controlled drugs in Canada?

Yes. In reported thefts and other losses involving narcotic and controlled drugs in 1982, large quantities of drugs were taken, including codeine (eg Paverol) [679,094 tablets and capsules, and 164 litres]; hydrocodone (eg Corutol) [1,849 litres and 32,719 tablets]; oxycodone (eg Supendol) [287,940 tablets]; pethidine (eg Demerol) [81,396 tablets and capsules and 20 litres]; and, pentazocine (eg Talwin) [88,673 tablets and 1.5 litres].

How much drug crime is there?

In 1982, there were 64,636 drug-related criminal offences, 45,720 Canadians charged, and 36,388 total convictions under the federal Narcotic Control Act.

On a per capita basis, the Yukon had the highest rate of offences, while the Yukon and Northwest Territories together had the highest rate of convictions.

How much legal aid assistance is related to drug cases?

In 1978/79, there were 9,230 criminal legal aid cases for offences under the Narcotic Control Act, accounting for 6.3% of all legal aid cases.

How many Canadians were sent to jail for drug-related offences?

In 1979, there were 482 admissions for drug-related offences to Canadian federal penitentiaries which hold prisoners sentenced to a term of two years or more, and another 820 admissions to provincial/territorial adult correctional institutions which hold prisoners sentenced to a term of less than two years.

How many Canadians have drug-related health problems?

There were 18,148 cases in general hospitals of drug psychoses; drug dependence; non-dependent abuse of drugs; and, poisonings by analgesics, sedatives and hypnotics, and psychotropic agents (1980/81). Another 1,088 cases were treated in mental and psychiatric hospitals for drug psychoses, drug dependence, and non-dependent abuse of drugs (1981/82).

On a per capita basis, British Columbia had the highest rate of drug cases treated in general hospitals, while Prince Edward Island and Nova Scotia had the highest rate for cases treated in mental and psychiatric hospitals.

How many drug poisonings are there?

In 1980/81, general hospitals treated 14,513 cases of poisonings by analgesics, antipyretics and antirheumatics, sedatives and hypnotics, and psychotropic agents.

Poison control centre statistics for 1982 report cases of drug poisoning by psychotherapeutic agents, sedatives and hypnotics, ASA (acetylsalicylic acid — eg Aspirin), acetaminophen (eg Tylenol), street drugs and glues and adhesives. The outcome of a poison episode depends on the kind and quantity of drugs taken. For cases dealt with on the telephone, the average number of drugs taken in 1982 was 1.3; treated cases averaged two drugs per episode; and, cases with fatal outcomes averaged 3.3 drugs.

How many Canadians die of drug-related disorders?

In 1982, there were 505 deaths from adverse or toxic effects of psychoactive drugs and 13 deaths from drug dependence.

On a per capita basis, British Columbia had the highest rate of drug deaths.

These data are based on administrative reporting systems, or on surveys of the general population. Estimates based on surveys are approximate figures only. The real figures may be slightly smaller or larger.

NEWS

Fat followers of OA forbidden favorite foods

By Betty Lou Lee

HAMILTON — A lesser-known, copy-cat organization based on Alcoholics Anonymous (AA) is marking its quarter-century birthday.

Overeaters Anonymous (OA), founded by two women in California in 1960, uses the basic AA text, substituting "food" for "alcohol," uses AA slogans and steps, and has the same buddy system — a person you can call if you're tempted to tear into a carton of cookies, as you would if you had the urge to open a bottle of rye.

The difference is that complete abstinence isn't a realistic goal with food.

Dick B., 48, of Ottawa, is an unlikely-looking OA member. He has weighed a lithe and lean 165 pounds for three years. But, a 10-year-old picture from his wallet shows a man weighing 285 pounds, 50 pounds down from his record of 335 pounds.

"I never ate at a normal level for one day. It was either binge or semi-starvation," he told **The Journal** during the 26th annual Institute on Addiction Studies at McMaster University here.

"The number-one symptom of compulsive eating is secret binges. You can always find times to eat alone."

The roommates of one young woman in his counselling practice couldn't understand why she weighed so much, since they seldom saw her eating much. She drove around in her car at night, bingeing from fast-food takeouts.

That's where abstinence comes into the OA program.

"Everyone has favorite foods to binge on. You isolate those and give them up completely," said Dick. He used to binge on two litres of ice cream with a can of chocolate syrup twice a day, and fortify that with chocolate bars and cookies.

Dick joined an Ottawa OA group seven years ago: "I haven't had any sweets for three years. I had about two months of withdrawal, but the craving goes away, and I've lost the taste for them."

When he realized he did a lot of bingeing when he was drunk, he went to AA, quit drinking "cold turkey," and then found he was better able to follow the OA program.

One practical technique is to write down everything you plan to eat that day — three moderate meals and no snacks — then telephone the list to your sponsor each morning.

"It's a powerful help," said Dick. "You might not follow the plan exactly, but your overeating becomes small . . . a 200-calorie deviation, not a 4,000-calorie binge."

These kids are immune to peers

MONTREAL — School children in an isolated, economically-depressed New Mexico town are being "psychologically immunized" against peer pressure to use alcohol and other drugs.

The prevention program, developed by University of New Mexico researchers and school personnel of Mora, New Mexico, was designed for the town's children, said Elias J. Duryea, PhD, an assistant health education professor at the university.

Classroom exercises incorporate the specialized drug problems which face Mora, Dr Duryea added. These are: excessive drinking; drinking and driving; accompanying a drinking driver; marijuana use; and, non-prescription drug use.

Dr Duryea: "Recreationally, the community is a paradox. Although located in scenic mountains, it has very few publicly-sponsored recreational facilities available."

Mora, with a population of 6,000, has 13 drinking establishments on its main street. The community has experienced high rates of alcohol- and other drug-related problems, and minors have "no problem procuring beer, wine, or liquor," Dr Duryea said.

The prevention program was field-tested and now operates throughout the academic years in grades seven, eight, and nine. Various techniques are used to build resistance among students.

For example, in a "responding to dares" exercise, the children learn how dares force them into acts they would normally find unacceptable. "They learn how to refute dares with health risks as their guide," Dr Duryea explained.

DEPARTMENTS

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation of Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000, ext 7384.

Becoming Laura

Number: 668.
Subject heading: Attitudes and values.
Details: 46 min, color.
Synopsis: Laura is 16 years old. She lives with her father and mother in a nice house and seems to have a very comfortable life. However, as we follow Laura through her day-to-day routine, we find that she is not so happy. She seems to be looking for something else. She decides to leave home and live with Chris, who is a "roadie" for his sister's rock band. Chris' sister tells Laura that Chris is a loser and she would be better off returning home and going to school. Laura also realizes life with Chris is not what she wants and tries going back home. This doesn't work out and we last see her working in a fast-food outlet, thanking her parents for letting her try to find out what she really wants.
General evaluation: Good (4.2). This contemporary, well-produced film realistically portrays what many young people and their families go through trying to decide what is best.
Recommended use: With a resource person, this film could lead to good discussion with teenagers and parents.

How Do You Tell

Number: 671.
Subject heading: Attitudes and values, drugs and youth.
Details: 11 min, color.
Synopsis: In the animated sequence of this film, children wonder how to tell their friends to be careful about things that may be dangerous. It is important to tell friends what you think and to suggest safe alternatives. Real people give their opinions on the effects of tobacco, cannabis, and alcohol.
General evaluation: Fair (3.3). Although this film could be used in developing social skills, the questionable drug information limits its use.
Recommended use: With a resource person to correct misconceptions, this film could be used with 8 to 11 year olds.

Kids and Drugs: The Reason Why

Number: 673.
Subject heading: Attitudes and values, drugs and youth.
Details: 15 min, 16mm only, color.
Synopsis: Maria believes she is not attractive and no one likes her. She is unsure about attending a party her friends are planning, to which each person is supposed to bring alcohol. She also resists peer pressure to smoke. Maria's principal tries to persuade her to come to a mural contest instead of going to the party. She is rejected by the group because she chooses the mural contest instead of the party, but her best friend eventually joins her at the contest.
General evaluation: Good (4.0). This contemporary, well-produced film could lead to good discussion about peer pressure. General broadcast was recommended.
Recommended use: With a resource person, this film could be used with those 12 to 14 years of age.

I Never Looked At It That Way Before

Number: 674.
Subject heading: Drugs and youth, attitudes and values.
Details: Two 10-min filmstrips with audio cassettes.
Synopsis: Young people often use drugs and engage in sexual activities without having all the facts about the possible consequences. It is suggested that adults are not trying to hassle young people when they warn their sons and daughters against engaging in such activities. Some possible results of drug abuse and sexual activities are discussed to get young people to look at their attitudes and make more informed decisions.
General evaluation: Very poor (1.4). These filmstrips tried to cover too much and were judged to be extremely moralistic.
Recommended use: None.

Books

Alcoholism and Substance Abuse: Strategies for Clinical Intervention — Bratter, Thomas E. and Forrest, Gary G. Free Press, New York, 1985. Etiological factors in the development of substance abuse and alcoholism; assessment of substance abuse and alcoholism; treatment modalities; special clinical issues. 650p. Collier Macmillan Canada, 50 Gervais Drive, Don Mills, Ontario M3C 3K4. $58. ISBN 0-02-904260-7.

Marijuana Alert — Mann, Peggy. McGraw-Hill Book Company, New York, 1985. Crisis in the workplace, armed forces, schools; health hazards; marijuana detection tests; successful school programs; programs in the workplace; parent movement. 526p. McGraw-Hill Book Company, New York. $10.95. ISBN 0-07-039906-9.

Alcohol Problems in Women — Wilsnack, Sharon C. and Beckman, Linda J. (eds). Guilford Press, New York, 1984. Patterns of alcohol use and alcohol problems in women; biological and psychosexual aspects; antecedents and consequences of alcohol problems in women; treatment and prevention of alcohol problems. 480p. Guilford Press, 200 Park Ave S, New York, NY 10003. $35. ISBN 0-89862-164-X.

Alcohol in Western Society from Antiquity to 1800: A Chronological History — Austin, Gregory A. ABC-Clio Information Services, Santa Barbara, 1985. Antiquity; Middle Ages; 16th, 17th, 18th centuries; designed to facilitate the identification and acquisition of historical data, and to assist in comparative analyses between eras, geographical locations, and strata of societies. 467p. ABC-Clio Information Services, 2040 Alameda Padre Serra, Box 4397, Santa Barbara, CA 93103. $60. ISBN 0-87436-488-3.

Psychosocial Issues in the Treatment of Alcoholism — Cook, David; Straussner, Shulamith A.L.; and Fewell, Christine H. (eds). Haworth Press, New York, 1985. Compatibility of the disease concept with a psychodynamic approach in the treatment of alcoholism; strategic treatment techniques in alcoholism treatment; loss and grief; integration of sexuality into alcoholism treatment; alcoholism in women; alcoholism and sexual assault; offspring with fetal alcohol effects; supervisory group process approach to address staff burnout and counter-transference in alcoholism treatment. 134p. Haworth Press, 28 E 22nd S, New York, NY 10010. $22.95. ISBN 0-86656-363-6.

This publication is indexed in

BIHEP
BIBLIOGRAPHIC INDEX OF HEALTH EDUCATION PERIODICALS

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:
a) Regular Line Rates $1.09 line
b) Standard Units of Insertion
1 Page (1,120 lines) $1,000
½ Page (560 lines) $500
¼ Page (280 lines) $250
c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation 27,318 (Canada 21,412, USA, 1,907, Foreign, 386, Bulk, 3,613)
Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents $16 per year
US & Foreign Residents $24 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.

The Journal, 33 Russell St
Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

DEPARTMENT

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Drug Education Coordinating Council Seminar on Contemporary Drug Issues — Nov 8, Malton, Ontario. Information: H.J. Schankula, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

Youth, Alcohol and Drugs: A Mini-Conference — Nov 14, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Awareness 85 — 1st Biennial Conference on Employee Assistance Programs in British Columbia — Nov 14-15, Richmond, BC. Information: Awareness 85, c/o 880, One Bentall Centre, 505 Burrard St, Vancouver, BC V7X 1M4.

Skill Training for Employee Assistance Personnel — Nov 17-21, Oakville, Ontario. Information: James Simon, Peel Centre, Addiction Research Foundation, 39 Dundas St E, Ste 203, Mississauga, ON L5A 1V9.

Addiction Awareness Week — Nov 17-23, throughout Ontario and other provinces. Information: Mary Pakula, Addiction Research Foundation, 175 College St, Toronto, ON M5T 1P8 or Joe Taylor, Vincentpaul Community Houses, 240 Church St, Toronto, ON.

The A's of Aging — Nov 20, Stratford, Ontario. Information: Ruth Lawson, Canadian Mental Health Association, Perth County, 380 Hibernia St, Stratford, ON N5A 5W3.

International Conference on Youth — Nov 20-22, Montreal, Quebec. Information: GEMS Conference and Consulting Services, 5003 Victoria Ave, Montreal, Que H3W 2N2.

Children of Alcoholics: A Painful Legacy — Nov 26, Toronto, Ontario. Information: Special Events, Addiction Research Foundation, 33 Russell St, Toronto, ON M5S 2S1.

23rd Annual Scientific and Business Meeting — Nov 27-30, Toronto, Ontario. Information: Ontario Chapter College of Family Physicians of Canada, 4000 Leslie St, Willowdale, ON M2K 2R9.

Ontario Hospital Association Annual Convention — Dec 2-4, Toronto, Ontario. Information: Warren Di Clemente, Ontario Hospital Association, 150 Ferrand Dr, Don Mills, ON M3C 1H6.

Scientific Meeting on Public Health and Health Services Research, Present — Future — Dec 3-4, Ottawa, Ontario. Information: Canadian Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, ON K1Z 8N8.

Alcohol and Other Drugs: You and Your Family — Radio course, begins Jan 6, 1986. Information: Open College, 297 Victoria Street, Toronto, Ontario M5B 1W1, or School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Group Therapy Course — Jan 20-24, 1986, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Ontario Psychiatric Association Annual Meeting — Jan 23-25, 1986, Toronto, Ontario. Information: Ontario Psychiatric Association, 1528A Dundas St W, Toronto, ON M6K 1T5.

Drugs, Drug Abuse, and the School System — Jan 28-29, March 25-26, 1986, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

The Street is No Place for a Kid: Symposium on Street Youth — Feb 10-12, 1986, Toronto, Ontario. Information: 1st Annual Symposium on Street Youth, Covenant House, 70 Gerrard St E, Toronto, ON M5B 1G6.

Ontario Psychological Association Annual Meeting — Feb 13-15, 1986, Toronto, Ontario. Information: Mona Abbott-Kesting, administrative officer, OPA, 1407 Yonge St, Ste 402, Toronto, ON M4T 1Y7.

United States

1985 Annual Conference of Substance Abuse Librarians and Information Specialists (SALIS) — Nov 6-8, New Brunswick, New Jersey. Information: Penny B. Page, chair, Center of Alcohol Studies Library, Smithers Hall, Busch Campus, Piscataway, NJ 08854.

Association of Labor-Management Administrators and Consultants on Alcoholism, 14th Annual Conference — Nov 10-14, Boston, Massachusetts. Information: Judith Evans, associate director, 1800 N Kent St, Ste 907, Arlington, Virginia 22209.

Immunopharmacology: Bridging the Disciplines — Immunology and Pharmacology — Nov 13-15, San Mateo, California and Dec 4-6, East Brunswick, New Jersey. Information: General Information, Institute for Applied Pharmaceutical Sciences, Box H, East Brunswick, NJ 08816-0257.

Association for Medical Education and Research in Substance Abuse, 9th Annual Conference — Nov 14-15, Washington, DC. Information: Dr G. Lewis, AMERSA president, Center for Alcohol Studies, Brown University, Box G, Providence, Rhode Island 02912.

Cocaine, The Clinical Challenge — 1st National Conference — Nov 17-19, New York, New York. Information: US Journal Training, Inc, 1721 Blount Rd, Ste #1, Pompano Beach, Florida 33069.

Good Laboratory Practices — Regulatory Requirements for GLP's — Nov 18-19, East Brunswick, New Jersey and Jan 16-17, 1986, San Francisco, California. Information: Institute for Applied Pharmaceutical Sciences, Box H, East Brunswick, NJ 08816-0257.

Regulatory Affairs (United States) Management in the Pharmaceutical Industry — Dec 2-4, Jamesburg, New Jersey. Information: Institute for Applied Pharmaceutical Sciences, Box H, East Brunswick, NJ 08816-0257.

10th Annual Southeastern Conference of Alcohol and Drug Abuse (SECAD 10) — Dec 4-8, Atlanta, Georgia. Information: Charter Medical Corporation, Addictive Disease Division, 5780 Peachtree Dunwoody Rd, Ste 170, Atlanta, GA 30342.

The Measurement of Alcohol and Drug Use in Individuals — Dec 6, Buffalo, New York. Information: Research Institute on Alcoholism, 1021 Main St, Buffalo, NY 14203.

International Congress and Exposition — Alcohol, Accidents, and Injuries — Feb 24-28, 1986, Detroit, Michigan. Information: National Highway Traffic Safety Association, 400 7th St SW, Washington, DC 20591.

American Pharmaceutical Association — March 15-20, 1986, San Francisco, California. Information: American Pharmaceutical Association, 2215 Constitution Ave, NW, Washington, DC 20037.

American Society for Clinical Pharmacology and Therapeutics — March 20-22, 1986, Washington, DC. Information: Elaine Gallasso, executive secretary, 1718 Gallagher Rd, Norristown, Pennsylvania 19401.

SECAD-West — Current Trends in Addiction — April 3-6, 1986, Denver, Colorado. Information: Barbara Turner or Pat Fields, Charter Medical Corporation, Addictive Disease Division, 11050 Crabapple Rd, Ste D-120, Roswell, Georgia 30075.

American Orthopsychiatric Association Annual Meeting — April 7-11, 1986, Chicago, Illinois. Information: Marion Langer, executive director, 19W 44th St, #1616, New York, NY 10036.

American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD) and the Research Society on Alcoholism (RSA) — Joint Meeting — April 18-22, 1986, San Francisco, California. Information: AMSAODD-RSA Meeting, 12 W 21st St, New York, NY 10010.

Abroad

2nd European Federation of Therapeutic Communities Conference — Nov 17-20, Bruges, Belgium. Information: M. Lutterjohann, Kaiserstrasse 10, D-8000 Munchen.

1st World Congress on Drugs and Alcohol — Dec 15-19, Tel Aviv, Israel. Information: Congress Secretariat, Peltours Ltd, Congress department, POI Box 394, Tel Aviv 61003, Israel.

Paraquat Symposium — Jan 27, 1986, London, England. Information: Dr G. N. Volnas, Poisons Unit, Avonley Rd, London SE14 5ER, England.

15th International Institute on the Prevention and Treatment of Drug Dependence — April 6-11, 1986, Amsterdam/Noordwijkerhout, Netherlands. Information: ICAA, case postale 140, CH-1001, Lausanne, Switzerland.

3rd Congress of the International Society for Biomedical Research on Alcoholism — June 8-13, 1986, Helsinki, Finland. Information: Ms Sari Salo, 3rd ISBRA Congress, Alko Ltd, PO Box 350, SF00101, Helsinki, Finland.

Benzodiazepines: another point of view

'A lot of people take them and don't get addicted'

BRIGHTON, England — Long-term use of benzodiazepines, and difficulties some people have in giving them up, have created for the mass media in North America and Western Europe a perpetual story: the Valium addict.

The scenario in print or film is almost always of an innocent patient — most often a woman — lured into dependence by an uncaring medical profession and a crass pharmaceutical industry. The struggle to give up the drugs is seen as tantamount to kicking heroin.

*Clinical evidence suggests another view. It is that most people prescribed benzodiazepines use them for only four to six months; most give them up without problems; and, while addiction is a reality, research in San Francisco and elsewhere (***The Journal***, December, 1982) indicates most benzodiazepine addicts also abuse other drugs, including alcohol.*

At the recent congress here of the World Federation for Mental Health, Charles Merrett, senior clinical psychologist, and Paul Grantham, clinical psychologist, of St James Hospital, Portsmouth, England, presented a report on their continuing research on The Valium Victim: Rhetoric or Reason. *Their interest has extended to publication of a monograph for laymen.*

Mr Grantham told **The Journa**l *that in their work at the psychiatric hospital, and with referrals from family doctors, he and Mr Merrett see a large number of clients addicted to drugs, including benzodiazepines.*

"While there is a lot of clinical evidence that benzodiazepines can be addictive, there is also lots of clinical evidence that a lot of people take them and don't get addicted," he said.

He and Mr Merrett are interested especially in researching the coping strategies of short- and long-term benzodiazepine users. "We think the long-term users end up coping in a different way, and a less effective way, perhaps, than the short-term users."

What they constantly have to do is tell people who feel they are addicted to benzodiazepines that withdrawal alone from use of the drug will not be the solution to their problems.

Mr Grantham: "The problem is that a lot of people are told they are going to be totally fine, that everything they are experiencing is due to the drug, and that, once they cut down, following an initial period of withdrawal they will be fine.

"People are always coming to us saying: 'Well, when is it going to finish? When is it going to get better?' And, of course, there is no answer to that. The only answer we can give is that things will get better when they learn to cope with situations in a different way."

Mr Grantham and Mr Merrett outlined the most popular models of benzodiazepine victims, their response and suggestions for treatment, at the congress. The congress was held in conjunction with the National Association for Mental Health in Britain (MIND). Contributing Editor **Harvey McConnell** *reports the team's views in synopsized form.*

McConnell

• The Addiction Model

The Addiction Model sees benzodiazepine nsers within the same psychiatric category as heroin nsers, cigarette smokers, or alcoholics. The primary problem is attributed to the drugs alone. Thus, users are more or less innocent victims.

In the popular literature on tranqnillizer use, the story nnfolds in a familiar manner. The individual has suffered an everyday, short-term psychological problem in the past, such as divorce or bereavement, and has long recovered. Bnt now, he or she cannot stop taking the drngs, realizes it is an addiction, and goes through agonies trying to stop.

The facts are, as British research in London and Liverpool demonstrates: 80% of those prescribed a benzodiazepine stop taking the drug within a six-month period and do not become long-term users. Among long-term users, 40% in a Liverpool study stopped taking the drug after receiving a letter from their general practitioner advising them to do so. Another 40%, with help, were able to stop or significantly reduce use.

The data show the vast majority of people prescribed tranquillizers do not become long-term users. These findings are inconsistent with some assertions that coming off Valium (diazepam) can be worse than coming off heroin. If only we could help narcotics users so easily — simply by getting their general practitioners to advise them to stop taking the drug.

The research seems to indicate we are not dealing with a simple pharmacological problem; there is a lot of individual variation in how difficult people find giving up tranquillizers.

from a long-term, possibly-incurable illness which necessitates taking drugs to make life bearable.

Again, research in Liverpool has shown not only that 40% of those who are long-term users stopped when advised to do so by letter from their doctor, but also a further 40% were able to give up altogether, or significantly cut down, following training in anxiety-management techniques.

The success of such non-drug intervention techniques casts doubt on the view that long-term tranquillizer users are suffering from an illness of some sort.

If symptoms are seen as part of an illness, then there is a tendency to dissociate them from problems of living.

• The Weak Individual Model

Within this model, the benzodiazepine user is seen as weak and suffering from immutable personality defects which require long-term tranquillizer use. These defects have arisen through traumas in the past that have shaped the person and made him or her unable to cope with life without the aid of drugs. Today, the traumas are repeated because of poor housing or intolerable marriages.

Again, the experience in Liverpool is revealing: if people are fixed in the way they are through past experience and present predicament, then one would not expect to see the success reported.

• • •

There are a number of implications arising from these models. The most vital is that the way we see people does inevitably affect the way we treat them and how they see themselves. To ignore this is dangerous.

With the "victim" models, it is always someone or something else's fault: drug, doctor, illness, or background. The user sees himself or herself, and is seen, as impotent to change the situation.

So often we see users who have been encouraged to view themselves and their situations in a totally helpless way. This is not a good foundation for helping a client change and deal with problems with tranquillizers.

There is the implication that the responsibility of dealing with the problem lies elsewhere.

There is responsibility and blame as well on the part of health care professionals. The doctor and the psychologist are deemed to know all about the problems, while the users know very little.

The effect is to foster professional kudos and power while, at the same time, disabling clients. If users are encouraged to see themselves as victims in some way, professionals are provided with a clear role as high priests to forgive or exonerate them of responsibility and guilt.

In addition, tranquillizer users are not encouraged to see how problems have arisen as a result of psychological reactions to events. And, if they are not encouraged to understand such reactions, they do not know how to change things. Many professionals only give a passing nod to such issues.

In our clinical work with tranquillizer users, we find their attitudes to their feelings (both while they are on the drugs and withdrawing) are of crucial importance. Anxiety in many situations is entirely normal and beneficial. It is only by beginning to accept these feelings as natural and not as evidence of sickness or weakness that users can begin to deal more effectively with them.

Clients must understand why they feel as they do. No professional understanding is of any use if it does not help clients make sense of what is going on. We have found that as users begin to make sense of how they have arrived at their present position — both in terms of what has happened to them and of their attitudes — their feelings become more manageable, and they can start to explore new ways of dealing with events and feelings.

We know some users find it hard to give up tranquillizers: the whole thing becomes a life or death issue, which it isn't. It is only when users begin to recognize how their attitudes to the drugs affect how they feel without them, that they start to change.

So often we are confronted by tranquillizer users who tell us how nice and caring we are compared with their 'horrible old general practitioner' who got them addicted to Valium. Despite the flattery, we don't actually consider this helpful. The user still is expecting someone else to take responsibility for decisions and feelings. The 'old' professional has failed the test, and so all hopes are pinned on the new one.

We feel no health care professional can fully help a client if he or she colludes with the client, appears to have all the answers, or takes responsibility for making his or her decisions. It is only when people begin to take such responsibility back that one begins to see any real or long-term change.

Finally, giving up tranquillizers involves change of some sort in the way people deal with feelings and experiences. Whether symptoms experienced after termination of benzodiazepines are a withdrawal phenomenon, or not, is a secondary issue.

• Medical Conspiracy Model

This is often attached to other models of the addiction hypothesis but brings in the medical profession and the pharmaceutical industry.

A common complaint of long-term benzodiazepine users is that they felt duped into taking the drug by family doctors, who, in turn, are at fault for being naive or ignorant about the effects of the drugs they prescribe. Doctors also have been described as hard-hearted and callous . . . and have even been accused of being benzodiazepine "pushers."

If the doctors are the "pushers," then their "French Connection" is the pharmaceutical industry, which is seen as rich, corrupt, and exerting undue pressure on doctors to prescribe their products.

There is no question that pharmaceutical companies are commercial enterprises which want to make a profit and, in the marketplace, will emphasize the advantages of their products and play down the disadvantages.

Equally important, but too often forgotten, is the fact drug companies do not just create opinion through advertising, they respond to it: we (the public) expect wonder drugs to cure our problems. We are more interested in what such drugs *can* do for us than what they *can't* do. And, the drug industry has capitalized on the fact we have always wanted people to sell us substances that make us feel better.

As for doctors, there is no doubt there are some who avoid listening to their patients' worries. But, patients often want quick and easy solutions. Both patient and doctor frequently collude in shying away from the psychological factors that led to the prescription.

• The Anxiety Neurosis Model

In this model, the problem is not the drug but the so-called illness which leads people to take the drugs in the first place. It is based on the assumption they become long-term users of tranquillizers because they are "mentally ill" with anxiety neurosis. Thus, the user is someone who suffers

THE BACK PAGE

INSIDE OUT

A new column — explorations of addiction from the inside out

p 5

China waging new war on tobacco

p 7

The Journal's 1985 INDEX OF HEADLINES

The centre section

Vol. 14 No. 12 2nd Class Mail Reg No. 2776 TORONTO, December 1, 1985

The Journal

Published monthly by Addiction Research Foundation WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

Drug paraphernalia sales must stop: Turner

By Harvey McConnell

WASHINGTON — The time is ripe for United States federal legislation to wipe out the sale of drug paraphernalia, says Carlton Turner, PhD, director of the White House Office on Drug Abuse Policy.

He told the annual conference here of the National Federation of Parents for Drug-Free Youth there has been success in drug awareness, education, and prevention campaigns, but inconsistencies must be ironed out.

Dr Turner acidly observed: "We have Mayor (Edward) Koch of New York wanting us to strip search people coming into our country with the military, to stop drug abuse, yet you can walk downtown in New York and you will find drug paraphernalia on sale.

"It doesn't seem to fit. It is now time for a national paraphernalia act to be passed."

(Anti-drug paraphernalia laws have been passed in 39 states.)

While progress has been made in highlighting the problems drug abuse causes in society, Dr Turner says: "We have to make an aggressive campaign now to make a real difference in what we perceive as drug abuse.

"It's strange to me that a person who is inebriated with alcohol and stopped at a road block pays the consequences; that a physician who writes a prescription for an illegal substance can lose his or her licence; that I can go in and con a physician out of a controlled substance and I can be arrested for possession; and, on the other hand, that a guy with a three-piece suit can sell cocaine on Wall Street to another guy in a three-piece suit, and it is 'no crime.' The user has to start taking responsibility."

This anomaly is being recognized more and more by industry, and there is a concomitant rise in urine testing. Dr Turner: "I don't think anyone has an inalienable right to use an illegal substance. I think he has an inalienable responsibility to be held accountable for his actions."

Later, surveying the world scene, Dr Turner told **The Journal**: "Right now, we are not going to slow down the world-wide epidemic of drugs. Use is rising in Europe; it is increasing in Asia where before there was only heroin and now several drugs are available; and, I don't think drug use in Latin America has peaked."

Commenting on his recent trip to South America, Dr Turner said much of the large-scale production of coca leaf is being orchestrated from outside. While a decade or so ago coca-leaf growing was a cottage industry, this is no longer true.

An illegal plantation he reached by helicopter in Ecuador, which had a processing laboratory onsite, was financed by Colombians, managed by a Bolivian, and employed only a few locals.

In Venezuela, marijuana production is in the hands of Colombians, and the start of coca-leaf growing is in the hands of Bolivians.

Teens doing fine, but for cocaine

TORONTO — Adolescent cocaine use in North America is accelerating and jeopardizing a consistent downward trend in most areas of drug use in recent years.

A large United States study — 16,000 high school seniors in 132 high schools by Lloyd Johnston, PhD, and colleagues at the University of Michigan for the US National Institute on Drug Abuse (NIDA) — finds in 1985 that cocaine has been tried by 17% of seniors. It is the highest rate yet recorded and covers every subgroup, from sex to geography.

A Canadian study, by Reginald Smart, PhD, of Ontario's Addiction Research Foundation, was of 4,154 students in grades seven, nine, 11, and 13 in 193 schools in the province of Ontario. It shows cocaine use increased overall to 4.5% in 1985 from 4.1% in 1983. In Metropolitan Toronto (Canada's largest city), the rise is dramatic: to 5.8% in 1985 from 3.2% of students in 1983.

Dr Johnston's study, which he has conducted annually since 1974 for NIDA, finds a five-year downturn in all drug use has levelled off in some cases (marijuana, tranquillizers, barbiturates, alcohol, and cigarettes). Use of phencyclidine (PCP), opiates other than heroin, and, most importantly, cocaine, has increased.

Dr Smart's study shows that 16 of 17 drugs — cocaine being the exception — declined in use since 1983, although there is still heavy use of alcohol and cannabis.

A warning of what cocaine is doing to US adolescents, and what could happen in Canada, has been given by Mark Gold, MD, a co-founder of the 800-COCAINE, hotline. (See page 3.)

International Youth Year round-up

Fundamental and social change

Workplace best for front line health care

By Elda Hauschildt

OTTAWA — The workplace could become an important setting for assessing and providing special health care needs as governments face harsh economic realities, says the associate deputy minister of Health and Welfare Canada.

"The workplace presents an optimum opportunity to identify special needs and provide appropriate responses," Maureen Law, MD, said here.

"People with personal problems seem to be more visible in the workplace; the expectations that accompany an employee are usually clearly delineated by definition of role and function.

"Thus, the norms of behavior are usually more clearly understood than perhaps even in the home or the community at large."

Health care in Canada is at a crossroads, Dr Law told Input 85, the 6th Biennial Educational Symposium on Employee Assistance Programs in the Workplace.

"We are at a crossroads where we must make serious choices about the directions and the future of the health of our people in light of economic reality," Dr Law said.

"In recent years, modern governments have been required to focus their efforts on cost savings and economic development issues. This has tended to shift emphasis away from quality of life issues."

Law: serious choices

Workplaces are really small communities in themselves, Dr Law said. "Two-thirds of the Canadian adult population — almost 12 million people — spend one-third of their adult lives at work.

"Workers are a heterogeneous population with varying social and cultural backgrounds and needs: male and female, able-bodied and disabled, well-educated and not educated, as well as representative of a variety of linguistic and ethnic groups.

"Like society, the workplace is also undergoing fundamental and social change."

Dr Law said alcohol-related medical costs in Canada are estimated at $2 billion annually, resulting in $1.2 billion in lost production costs each year.

"It is also estimated that 15% to 30% of the workforce is believed to be seriously handicapped by emotional problems at any time."

In addition to its employee assistance and health promotion in the workplace programs, Health and Welfare is looking at integrated models, access to special groups, and collaboration between government and workplace organizations in an effort to help contain health care costs.

"It appears the needs of employees will only be met through comprehensive approaches to multifaceted problems."

Draconian anti-drug measures for Britain

See page 2

INSIDE

NEWS

Briefly ...

A dash with flash

DENVER — Tipsy drivers will see red — on their dashboards — if they install the breath test system Guardian Interlock in their cars. The device warns drivers in green, yellow, or red about their alcohol levels. Motorists are supposed to blow into the machinery, which sits atop the dashboard, for four seconds before turning the ignition. While green means all's well, yellow warns a driver his legal limit is being approached. A red light leaves the car stalled and an impaired person stranded, says *The Toronto Star*.

Global ban

TORONTO — Canada's national newspaper — *The Globe and Mail* — has banished cigarettes from all general work areas. While the move has drawn praise from non-smoking activists, one reporter has complained in an article in *The Globe* that the newspaper has changed the rules of his employment midstream. Donn Downey says when he started 19 years ago no mention was made of a smoking ban.

R_x for confusion

TORONTO — Doctors who tell smokers to switch to low-tar cigarettes are helping the tobacco industry more than the patient, says a United States National Cancer Institute official. Low-tar cigarettes are the second leading cause of lung cancer after high-tar cigarettes in the US, says Dr Joseph Cullen in *The Medical Post*. "Acceptance of low-tar cigarettes as safe amounts to complicity with the (tobacco) industry," he said.

Lemonade Joe

MOSCOW — Soviet leader Mikhail Gorbachev's stand against excessive drinking has earned him the nickname "Lemonade Joe." While his measures have curtailed the number of drinking-related accidents and crimes, there is growing public resentment as queues form at liquor outlets. One drunk citizen here, hauled before a television camera to repent his drunkenness, was asked sternly by the moderator: "Why are you here?" His reply: "Guess I didn't run away fast enough (from the police)."

Coffee reviewed

WASHINGTON — The United States Environmental Protection Agency here is to speed up a review of methylene chloride — found in decaffeinated coffee, paint removers, and aerosol sprays — following evidence it is carcinogenic. Studies show that the chemical causes cancerous lung and liver tumors in mice and a variety of tumors in rats, says a report in *The Medical Post*.

FOREST lights up

LONDON — Smokers' rights campaigners are lobbying health union leaders here to defend members who want to smoke at work. FOREST, the Freedom Organisation for the Right to Enjoy Smoking Tobacco, is pressing relevant unions to support nurses who wish to have facilities available to smoke a cigarette before, during, and after work, says *Doctor*.

Vancouver data could alter prevention campaigns

Teen tobacco addiction linked to stress

By Heather Walker

VANCOUVER — A researcher here believes the results of her study of teen smoking patterns could lead to profound changes in anti-smoking campaigns.

Patricia Hadaway says the study of about 2,000 Vancouver-area junior high school students suggests they are addicted to cigarettes not because of nicotine but because cigarettes help them to deal with chronic stress.

Teens who smoke also frequently exhibit other behaviors indicative of poor ability to cope with stress, she told **The Journal.**

A doctoral candidate in psychology at Simon Fraser University, Ms Hadaway says the data have not yet been fully analyzed. However, she said: "There is some evidence that smokers are also often the students who do less well in school, who may be in trouble with the law, or may be in trouble at school, because of not showing up, for instance. Or, they may tend to use other drugs. So smoking tends to go along with other problems."

The survey covers both smokers and non-smokers and attempts to determine possible relationships between smoking and stress levels. It also looks at the students' need to be accepted by their peers and at their degree of social competency.

"Smokers seem to have more of a need to be accepted . . . . There is evidence smokers are more social than non-smokers, and that acceptance from their peers is more important for them than for non-smokers."

Because she believes smoking is related to inability to cope with stress, "I also wanted to check things related to social competence, so there are questions about whether they have part-time jobs, what school activities they're involved in, things like that."

Another preliminary finding is, at least in the Vancouver area, that girls are heavier smokers than boys.

"Because it's a large sample, it could say a lot about the relationship between stress and smoking." However, she said, because it was only done in one area, "it's not significant in terms of saying that in Canada more girls smoke."

Ms Hadaway says anti-smoking programs should include help for people in handling stress.

"We have to keep all programs that are already in existence, because there is a group who have been convinced not to smoke because of the health risks, for instance. But, evidence that smoking is unhealthy will not affect those with distress and who start to smoke to cope with distress.

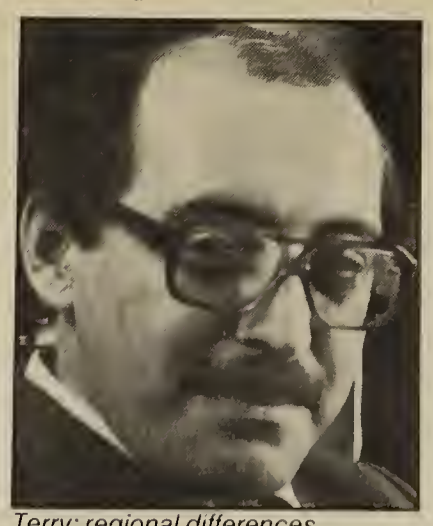
"We have to develop programs to help teenagers to deal with stress, and we have to give them alternatives to smoking."

Senate youth probe to address drugs

By Elda Hauschildt

OTTAWA — Alcohol and other drug problems affecting the young are expected to be prominent in the upcoming report of Canada's Special Senate Committee on Youth, although youth employment will dominate.

The Senate committee's mandate is "to examine, consider, and make recommendations on the problems and issues facing Canadian youth between 15 and 24 years of age."



Terry: regional differences

Twelve senators are on the committee, which held hearings across Canada during 1985, the United Nations' International Youth Year. The committee's report will be issued early in 1986.

"There will be some discussion of drug and alcohol problems in the report," John Terry, committee research director, told **The Journal.** "But, I can't say if or to what extent solutions to the problems will be recommended."

During public hearings, held in the capital or largest city in each province, and in Ottawa, alcohol and other drug problems among youth were discussed. The topic also surfaced in many of the more than 200 written briefs submitted to the committee.

"We wanted to hear from a cross-section of both youth themselves and agencies serving youth to get an idea of regional differences in problems and concerns," Mr Terry explained.

Concerns on alcohol and other drug problems were voiced across the country, with submissions ranging from briefs by addictions agencies on their work, to data linking drug problems with youth suicide, to evidence by a recovering addict on the cost of his rehabilitation.

Jan Skirrow, executive director of the Alberta Alcohol and Drug Abuse Commission, told the committee in Edmonton of the "tremendous differences within the age group being surveyed.

"Our approach to those in their early 20s would be much more of what I would call secondary prevention, that is, early identification of high-risk individuals and then attempting to get them into treatment.

"By the time we get to that point, they have already formed a reasonably permanent pattern, which will stick with them unless there is significant intervention. Primary prevention is something that is very hard to do once people get out of their teens."

Simon Davidson, MD, director of out-patient psychiatry at Children's Hospital of Eastern Ontario in Ottawa, told the committee of findings that "each year at least 1% of drug-addicted youngsters die because of suicide, homicide, and drug-related medical problems."

Greg MacKinnon, a volunteer with Prince Edward Island's Alcohol and Drug Problems Institute, spoke to the committee in Charlottetown:

"I was a teenage drug addict and alcoholic from the age of 13 years. As a result, I was involved in many of society's attempts in dealing with my problems, all of which failed. . . . I have cost society approximately half a million dollars. I refer to the costs of keeping me in hospitals, jails, mental institutions, detoxification wards, and so on. That is what it cost to do it improperly.

" . . . Drug addiction kills people. I came from a town of 2,500 people and I have 17 dead friends, the oldest being 24 years. Many youths today are disillusioned and, while not everybody is turning to drugs and alcohol, the numbers are growing. These kids come out of school, they are faced with the prospect of no work, and all they hear in the media is about Reagan and Gorbachev talking about dropping bombs on each other."

Britain will freeze assets of drug traffickers

By Alan Massam

LONDON — The British Government has announced the most Draconian measures ever taken in peacetime to curb drug smuggling.

A new act of Parliament will give the police powers, with High Court sanction, to freeze the assets of anyone involved in trafficking or "laundering" money from drug transactions.

The new offence of handling the proceeds of drug trafficking will carry a maximum 14-year jail sentence, plus confiscatory fines equal to the full value of the drugs exchanged in the transaction.

And, for the first time, the burden of proof will rest with the alleged offender. Dealers will have to prove that their assets, including homes, cars, and yachts were not bought with drug profits.

Announcing the new moves, Home Office Minister David Mellor said at the Conservative Party conference in Blackpool that if the drug menace was not checked, Britain would slide down the same slope as the United States.

The strength of the proposals, however, is widely felt to have the mark of Prime Minister Margaret Thatcher.

Mrs Thatcher announced in August that the government was determined to win the war against narcotic dealers. "We are after you," she said. The government does not appear willing to take a softer line with the victims of drugs.

As part of its contribution to public spending cuts, the Home Office has warned that it may no longer fund rehabilitation hostels for drug offenders.

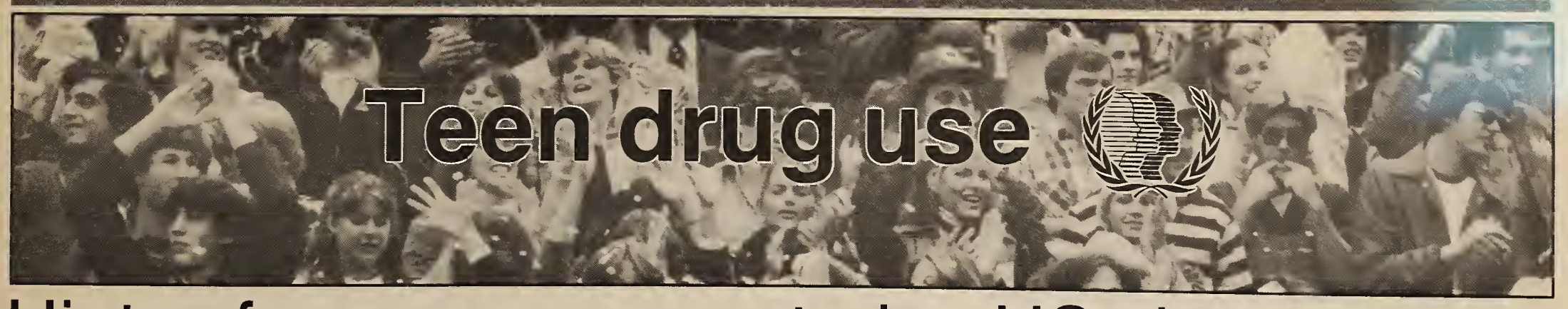
Mellor

A government source said the proposal probably reflected the feeling among Home Office officials that rehabilitation should properly be the province of another government department, health and social security. Secretary of State for Health Norman Fowler is expected to resist the idea vigorously.

— coming up in —

THE JOURNAL

- *Cocaine — the clinical challenge*
- *Responsible beverage service — issues for the future*



Teen drug use

Hints of concern now entering US picture ....

By Harvey McConnell

ANN ARBOR, Mich — The steady, if gradual, decline in drug use by United States young people is "showing signs of coming to an end." This is the sobering view of Lloyd Johnston, PhD, on his 1985 survey findings.

Two decades in which drug use constantly rose began to level off around 1980 and then started to decline — until 1985. Now, the only drugs which continue to show a drop in use are amphetamines, methaqualone, and LSD.

At the same time, Dr Johnston and his colleagues do not wish to paint a completely negative picture: it would be foolish to underestimate the substantial improvements which have been made through the years.

"Daily marijuana use now is less than half of what it was in 1978 (5% vs 11%), and the statistics for a

Johnston: troublesome

number of other drugs are appreciably lower now than they were at their peak levels, including tranquillizers, barbiturates, LSD, phencyclidine (PCP), and heroin.

"However, the rates of illicit drug use which exist among US young people today are still troublesomely high and certainly remain higher than in any other industrialized nation in the world.

"Add to that the fact that use of one of the most dependence-producing substances known to man — cocaine — is once again increasing, and you have grounds for real concern."

Cocaine has not only been tried by the highest number yet observed in the continuing study — 17% — its use is up in virtually every subgroup Dr Johnston and colleagues examined: males and females, college-bound and non-college-bound students, those in urban and rural areas, and those in all regions of the US except the South.

Though the increase for 1985 is not dramatic, it does break a pattern of stability which has held for the preceding five years.

There is another worry for Dr Johnston and colleagues: a likely substantial increase in cocaine use by the same high school seniors during the next several years. A postal follow-up survey of some members of the class of 1978 has found that only 10% had tried cocaine in their senior year, but close to 40% had tried it by the time they reached the age of 27 years.

Some of the views of the 1985 seniors are contradictory: about 80% consider regular cocaine use is harmful, but only 34% think there is much risk in experimenting with cocaine.

Dr Johnston said a close monitor has to be kept on PCP use: only about 5% of students have tried the drug, it is used only in a few large cities, and the 1985 rates are more than 50% lower than in 1979. But, because of the extreme dangers associated with PCP use, even use by 5% must be closely followed.

Overall, the study found that 51% of the seniors said they have tried an illegal drug at some time in their lives, and 40% have used an illegal drug other than marijuana.

Approximately 15% of the students reported active use of an illicit drug other than marijuana in the month prior to the survey, and 15% reported using only marijuana.

There has been a slight increase in daily alcohol use, which now stands at 5%, although a slight decrease was reported in monthly and yearly use. Heavy drinking bouts — five or more drinks in a row sometime during the prior two weeks — continued to decline, to 37% this year from 39% in 1984.

Dr Johnston still finds the figures disturbing: 45% of the boys and 28% of the girls reported drinking this heavily at least once in the prior two weeks.

Although daily cigarette smoking among the seniors rose to 20% in 1985 from 19% in 1984, this is still in sharp contrast to the 29% who reported daily smoking in 1977.

.... Ontario students becoming 'more cautious'

By Terri Etherington

TORONTO — Unprecedented, across-the-board decreases in drug use by Ontario students are marred only by a slight increase in cocaine use, reports a study by the Addiction Research Foundation (ARF) here.

Sixteen of 17 drugs studied showed declining use by young people since the last survey in 1983. Use in eight of the drug categories (tobacco, glue, other solvents, medically-prescribed barbiturates and tranquillizers, and non-medical barbiturates, tranquillizers, and stimulants) declined significantly. Use of all others except cocaine showed some decrease.

Reginald Smart, PhD, director of prevention studies at the ARF and senior author of the survey, called the results striking. "Young people are becoming more cautious about drug use.

"We have never found such a large number of declines since we began doing surveys in the 1960s," Dr Smart told a seminar here on Contemporary Drug Issues.

"Many types of drugs have returned to levels of use that were not seen since 1977 or even earlier."

But, while cocaine use among Ontario students remained relatively stable (increasing to 4.5% this year from 4.1% in 1983), use by young people in Metropolitan Toronto showed a dramatic upswing, almost doubling, to 5.8% of students surveyed, from 3.2% in 1983.

The ARF has been conducting biennial surveys of students in Toronto since 1968 and across the province since 1977. The 1985 survey questioned 4,154 students in grades seven, nine, 11, and 13 in 193 schools.

"The declines in drug use were most prominent for these groups: students in grade nine, males, and students in Eastern Ontario," Dr Smart said. "But, the declines were very broadly-based on the population as a whole."

The researchers were "heartened" to see that the proportion of students reporting no use of any drug, including alcohol and tobacco, increased to 26.7% in 1985, from 23.3% in 1981.

Dr Smart said the results "fit with findings from other places and also with changes in attitudes about drugs."

But, he said, "even though the results are encouraging, we should emphasize that drug use has not disappeared as a problem."

In addition to increases in cocaine use, heavy use of alcohol and cannabis did not decrease, and more than 30% of students still used drugs other than tobacco and alcohol.

"Clearly there is a great deal more to do in prevention and treatment."

Fred Burford, chairman of the Drug Education Coordinating Council which sponsored the seminar, told **The Journal** the Ontario results can be translated into a trend to declining drug use in Canada.

"Ontario is a pretty good barometer for Canada. If use is going down here, it is probably going down in other areas."

On the other hand, he said, United States data "cannot be translated to Canada. Everything is so different — the political outlook, the way young people and the population in general respond to educational programs, to the judicial system — are different in Canada than in the United States."

The Ontario survey also found:

- Alcohol is still the most popular drug among students, with 69.8% reporting use in the past year. Other drugs are used by less than 25% of the student population. Tobacco is used by 24.5%, and 21.1% reported using cannabis, the lowest rate since provincial surveys began in 1977. These three drugs account for 73.3% of all reported drug use among students.
- Reported use of other drugs was as follows: non-medical stimulants, 11.8%; medical barbiturates, 9.0%; LSD, 7.4%; other hallucinogens, 4.8%; medical tranquillizers, 4.7%; cocaine, 4.5%; non-medical barbiturates, 4.4%; medical stimulants, 4.3%; non-medical tranquillizers, 3.3%; speed, 3.1%; PCP, 1.7%; and heroin, 1.5%.
- While fewer students reported using drugs, those who do use clearly indicated they have not decreased frequency of use.

Smart: results encouraging

Other authors of the Ontario study were Michael Goodstadt, PhD, ARF director of education research, and Edward Adlaf, ARF senior research assistant.

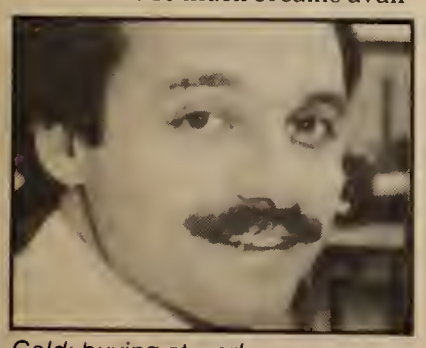
... complacency could open Canada to cocaine

By Elda Hauschildt

OTTAWA — Canada can avoid a cocaine epidemic like the one sweeping the United States by educating Canadians on the dangers of the drug, says Mark Gold, MD, co-founder of the US 800-COCAINE hotline.

But, he warns, Canadians need to act immediately.

"There is so much cocaine available now that the US isn't using up to four-fifths of the supply. That four-fifths is going to go anywhere spending money is available."



Gold: buying at work

Director of research at Fair Oaks Hospital, Summit, New Jersey and Boca/Delray, Florida, and Regent Hospital, New York, Dr Gold points out the most frequent means of distribution of cocaine is by private aircraft.

But, an epidemic would follow in Canada only "if everyone is asleep at the switch," he told 500 delegates here at Input 85.

"The single, best treatment for cocaine addiction is prevention — re-educating (because of misinformation accepted as truth), defiling the myths surrounding cocaine, and getting people to understand the drug really is dangerous."

Input 85, co-sponsored by Humber College, Toronto and the Canadian Addictions Foundation, was the 6th Biennial Education Symposium on Employee Assistance Programs in the Workplace.

In the US, Dr Gold says, people mistakenly looked at cocaine as a regional problem — "only in Miami, only in Hollywood, only in New York."

Today, "25 million people in the US have tried cocaine and five million users are out of control," he said. And, cocaine is a multi-billion dollar business.

"How do they do that much business each year, without commercials? Part of the credit goes to celebrities who, particularly in the late 70s, endorsed the drug. There were powerful cocaine jokes and a whole series of pro-drug, pro-cocaine movies, rock shows, etc."

In New York, Dr Gold says, "cocaine is widely available in every major office building; most users buy their supply in or around work."

Calls to 800-COCAINE — more than 1.3 million have been received since the hotline was established in May, 1983 (**The Journal**, October, February; November, May, 1984; July, 1983) — indicate that while adults are paying attention to negative reports on cocaine now appearing in the US press, adolescents are not.

"Twenty percent of the hotline calls are now coming from US campuses," Dr Gold said. "In 1983, our calls showed 99% of cocaine users were adults and 1% were adolescents; in 1985, we know 93% of users are adults and 7% are adolescents."

Cocaine is the only drug whose use by adolescents is increasing: "Alcohol use is steady or declining; marijuana use is decreasing; tobacco use is decreasing. But, there is a new market here for cocaine," he said.

New forms of cocaine are being developed for the adolescent market — "rock" and "crack" (for smoking without having to prepare the drug) — as one in five adolescents in the US try cocaine, Dr Gold says.

Adolescents calling 800-COCAINE report a variety of problems with cocaine use: 92% report health problems, 64% say they steal, 32% say they deal. Another 61% say they use allowances to buy drugs, 57% buy drugs at school; 69% report lower grades, 75% absenteeism, and 43% discipline problems.

Dr Gold blames medical misinformation that cocaine was safe; the chic cocaine 'mystique;' celebrity endorsement; and pro-drug messages in entertainment with spreading a cocaine 'message' throughout the US.

NEWS

RESEARCH UPDATE

PCP traces found in hair

A successful method of analyzing hair to detect previous phencyclidine (PCP) use has been reported from California. Researchers from a number of Los Angeles centres used the radio-immunoassay technique with hair specimens of 10 to 20 strands in newly-admitted psychiatric patients. To establish reliability, verified non-users of PCP and volunteers admitting to frequent PCP use during at least the last six months were treated. No false positive or negative results were obtained. Hair analysis, in addition to traditional methods of PCP detection from blood and urine samples, was then obtained from 31 consecutively admitted psychiatric patients and 16 patients selected by the admitting psychiatrist for PCP testing on the basis of either history or presenting symptoms. Of these 47 patients, hair analysis detected 11 who had used PCP, while blood and urine analyses did not identify any positive samples. Although urine testing is more likely to identify PCP than blood testing, the researchers noted eight patients refused to provide a urine sample. Four of these were identified as PCP users by hair analysis. In three patients, the results of hair analysis helped establish a diagnosis of PCP intoxication. While it is not known how the rate of appearance and accumulation of PCP in hair changes with time or is influenced by individual variation, PCP is apparently trapped in the hair during growth in amounts thought to correlate directly with the dose consumed.
American Journal of Psychiatry, Aug 1985, v.142:950-953.

Vascular effects of caffeine consumption

Caffeine increases blood pressure by increasing systemic vascular resistance, say researchers from the University of Oklahoma Health Sciences Center and the research service of the Veterans Administration Medical Center in Oklahoma City. They used a placebo-controlled study design with 15 healthy, male subjects who were low-to-moderate caffeine consumers. Using a double-blind, crossover procedure, subjects were given the equivalent of two to three cups of coffee in the form of oral caffeine on two days and placebo on one day, during a week of caffeine abstinence. Measurements of blood pressure, heart rate, systolic time intervals, and thoracic impedance measures of ventricular function were taken before and after caffeine consumption. The caffeine increased systolic and diastolic blood pressure and decreased heart rate, with the pressor effect credited to progressively-increased systemic vascular resistance. This resulted in greater stroke work by the heart. Cardiac output or contractility were found to be unchanged. The researchers concluded this enhancement of vascular resistance did not result in values exceeding the normal range in the young, healthy subjects tested, however: "the consequences of regular caffeine use by patients with systemic hypertension or other cardiovascular diseases need to be thoroughly examined in light of caffeine's vascular effects."
American Journal of Cardiology, July 1, 1985, v.56:119-122.

Laryngectomy lessens nicotine appetite

Smokers who have had their larynges removed because of cancer often are dissatisfied with the smoking experience. That's the finding of two British researchers who received survey responses from 171 laryngectomy patients, 76% of whom had been smokers at the time they sought help for their throat condition. Of this group, the researchers found, 40% tried smoking again after surgery, a proportion slightly less than the proportion found to smoke after surgery for lung cancer. They also reported that this percentage had fallen to 19% by the time the questionnaires were filled out, an average of five years after the operation. The majority of subjects said they stopped smoking because of the loss of satisfaction, while a smaller group indicated they wanted to avoid further risks to their health. The researchers said two contradictory consequences of laryngectomy exist for smokers. Both stem from the fact that smoke drawn into the mouth cannot be inhaled directly, they said, resulting in a lessening of risk because the smoke cannot reach the lungs and a reduction in satisfaction because of an inability to obtain accustomed plasma concentrations of nicotine. They said the study indicates a substantial minority of smokers will persist in the habit after laryngectomy despite this failure to obtain their accustomed nicotine plasma levels. Some will continue to smoke pipe tobacco or cigars, which permit more efficient absorption of nicotine from the oral cavity.
British Medical Journal, Aug 24, 1985, v.291:514-515.

Drowsy kids and drunkenness

Alcohol intoxication may be under-diagnosed in children admitted to hospital, say three Scottish researchers. The researchers from the department of child health, University of Aberdeen, reported on eight children aged 12 years or less, admitted to pediatric wards in Aberdeen with acute alcohol intoxication between January, 1983 and Feburary, 1984. In four cases, alcohol intoxication was not suspected until elevated blood alcohol concentrations were demonstrated by a toxicology screening. An alcohol-related smell was not detected on the breath of three of the four patients and, the researchers said, the parents were reluctant to admit even the possibility of alcohol use. The children, "in turn, rarely volunteered the information." The researchers said their experience "shows the importance of considering alcohol intoxication in children with unexplained drowsiness, hypoglycemia, or hypothermia." They added the mode of presentation may be confused with behavior following events such as a head injury.
Archives of Disease in Childhood, Aug 1985, v.60:762-763.

Pat Rich

Older women in Canada hit by tranquillizer script shift

By Betty Lou Lee

OTTAWA — There has been a dramatic switch from long- to short-acting benzodiazepines. And, elderly women — rather than those who are middle-aged — now receive more prescriptions for these drugs than any other age group.

These trends come from a study of 11,000 Ottawa residents served by 30 physicians in the Ottawa Civic Hospital Family Medicine Centre. A computerized record of all drugs prescribed has been kept there since 1977.

Walter Rosser, MD, chairman of family medicine at the University of Ottawa, reported the data at the annual meeting here of the Canadian Medical Association.

(Short-acting benzodiazepines, such as oxazepam, are eliminated from the body in three to 10 hours and are recommended as sleeping tablets rather than to reduce anxiety. The shift, says an Addiction Research Foundation scientist, may point to a change in indications for which the drugs are being prescribed: fewer are prescribed to the middle-aged for anxiety and more to the elderly for sleep.)

In 1985, short-acting benzodiazepines (oxazepam) accounted for 81% of prescriptions for this class of drugs, while in 1978, long-acting products (diazepam) accounted for 81% of prescriptions.

In 1978, middle-aged women had the highest rate of prescriptions. But, in the past year, the prescription rate for women older than 65 years has been 439 per thousand, compared to 166 per thousand for women 45 to 64 years old. The comparable rates for males are 307 and 95.

For those 15 to 44 years old, the rates are 26 for females and 10 for males.

In 1982, of 410 patients who got these prescriptions, 48% got only one, for 30 to 40 tablets, Dr Rosser said. Five percent got more than 700 units, more than two pills a day for the year.

Dr Rosser: "Several studies have indicated that people at risk for serious withdrawal symptoms have taken the equivalent of four or more units a day for at least one year's duration." Of the 21 heavy users in the study, "only five might be considered at serious risk for withdrawal reaction."

Later, Dr Rosser told **The Journal** benzodiazepines were prescribed to only one-third of patients in the study in acute stress situations, and he suggested they may be under-prescribed.

"Young doctors are tuned in to not giving them, which can be just as inappropriate as over-prescribing. They are safe and effective and, if people need them, why not give them? Aspirin (acetylsalicylic acid) is more toxic than Valium (diazepam). We had four Aspirin deaths at Ottawa Civic last year, but we've never had a Valium death.

"They (prescriptions) shouldn't be the first thing that come to mind when a patient is anxious — exercise, relaxation techniques, and self-hypnosis are some of the things that can be tried first."

Patients, too, are leery of the drugs, Dr Rosser added.

"The drugs are not as bad as they are touted. A few people who got addicted got a lot of publicity . . . the public press is against them." (**The Journal**, November)

Of the four men among the 21 heavy users in Dr Rosser's study, three had a history of alcohol or other drug abuse, three were unemployed, and three lived alone following a family breakdown.

Of the 17 women, aged 50 to 78 years, 47% had histories of serious marital or family problems, 41% had multiple, major medical problems, and 41% had personality disorders.

Substance abuse by seniors up

MONCTON — Substance abuse undermines the independence, the health, and the well-being of countless older adults, says Joseph MacIntyre, executive director of the New Brunswick Alcoholism and Drug Dependency Commission (ADDC).

And, cooperation is necessary if the problem is to be solved, he told the annual meeting here of the New Brunswick Senior Citizens' Federation.

In Canada, he said, people 65 years and older receive 21% of Valium (diazepam) prescriptions, 23% of Librium (chlordiazepoxide), 30% of Dalmane (flurazepam), 21% of Elavil (amitriptyline), and 27% of phenobarbital.

People in the same age group also rank as the heaviest drinkers.

In North America, he said, more than 7,000 drugs are being prescribed to older people on a regular basis. While only 10% of the population, the elderly consume about 25% of all prescription drugs. (A Michigan study found one in four seniors taking four or more prescription drugs at once.)

Mr MacIntyre said the elderly "are also frequent users of over-the-counter drugs such as antacids, analgesics, sleep aids, cough medicines, antihistamines, decongestants, laxatives, and vitamins."

The emotions related to medical diagnosis or hospital discharge — even the trauma of the relocation of going home — are factors which can make it difficult for a patient to comprehend advice and directions given by physicians respecting prescriptions.

In what he described as "but a small step in the direction of trying to provide a solution to the prescription drug problem," Mr MacIntyre said the ADDC, in conjunction with the Senior Citizens' Federation and the Provincial Pharmacists' Association, has produced a booklet: *Your Medicine and How To Use it Safely — A Guide for Senior Citizens.*

". . . If we pull together, we can create some innovative answers to the complex problems of alcoholism and drug dependency."

Nurses aiding addicted peers

By Maureen Brosnahan

WINNIPEG — Manitoba nurses have become the first in Canada to endorse eslablishment of a peer-support committee to help their alcoholic and other drug dependent colleagues.

The Manitoba Association of Registered Nurses (MARN), the standards and licensing body for about 9,000 nurses in the province, endorsed a resolulion to set up the committee at a recent annual meeting here.

The committee had been planned for several months, although the nurses voted against a similar resolution in 1984. At that time, many questioned the value of such a committee, arguing it would only duplicate existing services of social agencies. They requested then that more information about nurses' addictions be provided.

Committee chairman Norma Busby said while there are no national statistics available on the extent of the problem among Canadian nurses, data from the United States suggest at least 10% to 15% of nurses are addicted to alcohol or other drugs.

But, she said nurses are reluctant to seek help, even though many have access to employee assistance programs. "These haven't worked for nurses," she said.

Ms Busby says a nurse's role as a caring professional also puts her or him at a higher risk of addiction. Many nurses feel they should be the helpers, not the ones needing help.

Eleanor Giffin, MARN president, lold **The Journal** she's delighted nurses endorsed the committee's formation. "I would have been so disappointed; we worked so hard on that."

Ms Busby said nurses are the last large, health-professional group to establish at-risk committees. Even recovering nurses are unwilling to step forward for fear of reprisals.

"In nursing, the batting average has not been good. Recovering nurses are staying in the closet."

Ms Busby is confident the committee will help many good nurses who might otherwise quit their jobs when their addiction problems become uncontrolled and who would then be lost to the profession.

MARN has allocated the committee $8,400 for start-up and operating costs in the coming year. The committee's operating costs are estimated at $6,600 a year.

Nurses who volunteer to work on the committee will undergo training soon on how to approach and deal with peers who are referred to the group. The volunteers will be trained to counsel and offer treatment in confidence. Addicted nurses will be able to turn to the committee without fear of disciplinary action from the nursing body.

Committee members will also be sent to talk to nursing students. "Our emphasis for the first year will be on education," says Ms Busby.

NEWS

Research sounds fetal tobacco syndrome alert

LEXINGTON — Infants of women who smoke heavily during pregnancy may be at high risk of multiple birth defects.

Pediatrician Bryan Hall believes he has identified a consistent and distinct pattern of birth defects caused by heavy maternal smoking. The previously unidentified pattern of anomalies consists of mental retardation, abnormal facial features, heart defects, and hypospadias (the urethra opening on the underside of the penis or on the perineum) in males.

"These findings are still preliminary, but I have a strong, gut feeling that there is a direct relationship between heavy maternal smoking and birth defects," said Dr Hall, pediatrics professor and director of the division of genetics and dysmorphology at the University of Kentucky here.

Dr Hall is conducting a prospective study and hopes his findings will prompt other investigators to look into maternal smoking history in infants with a similar pattern of defects and, in whom other causes of congenital anomalies have been excluded.

"If other investigators start looking for this, we can arrive at a definite conclusion sooner," Dr Hall said. "I can't gather enough cases by myself for a proper statistical analysis."

While it has been known for several years that even moderate smoking during pregnancy significantly raises the risk of low birthweight, no other defect has ever been consistently linked to maternal smoking, Dr Hall said. And, no previous study has investigated the effects of heavy smoking.

"Earlier studies tended to use one pack a day as their cutoff," he said.

The mothers of the 25 infants studied by Dr Hall and colleagues smoked from two to five packs of cigarettes per day. The main anomaly seen in the children was abnormal facial development.

Dr Hall: "The children had small lower jaws, small and thin mouths, the nasal tip was blunt and upturned, and they had a persistence of epicanthal folds. There was also an increased frequency of heart defects, hypospadias in males, microcephaly, and mental retardation.

"We also found some interesting things regarding the newborn period. There was an increased frequency of seizures, low blood sugar, high hematocrits, and lower than normal birthweights for gestation."

The severity of the defects ranged from subtle to a very prominent pattern suggestive of a generalized adverse effect.

Dr Hall identified the possible link between heavy maternal smoking and a characteristic pattern of birth defects during an examination of children with multiple anomalies, in whom a diagnosis had previously been unestablished. The children and maternal histories were carefully examined and all possible causes of the anomalies were investigated.

"We excluded all possible drugs, inherited patterns of malformations, and chromosome disorders. We did all the appropriate lab tests, such as metabolic studies and chromosome analysis. In the end, every possible known cause was excluded. We were left with one common factor: the mothers of all of these patients were very heavy smokers during pregnancy."

Not only the number of cigarettes smoked per day, but also the duration of smoking appears to increase the risk to the fetus. "We see a lot of women who have had five or six kids and who have been smoking for 25 years by the time they have their last child," Dr Hall said. "They tend to produce smaller and smaller children the longer they smoke."

Dr Hall said Kentucky is a particulary good state in which to carry out such a study.

"In Kentucky, it's not socially appropriate for women to drink, but it's considered alright for them to smoke. So, we see a lot of women who are heavy smokers, but not heavy drinkers."

Wales wages war on drug abuse

CARDIFF — Wales has adopted stringent laws and developed aggressive campaigns to deter its young people from using drugs.

Wyn Roberts, undersecretary of state for Wales, told a conference here "organized crime is viciously and cynically exploiting young people to encourage them to use drugs.

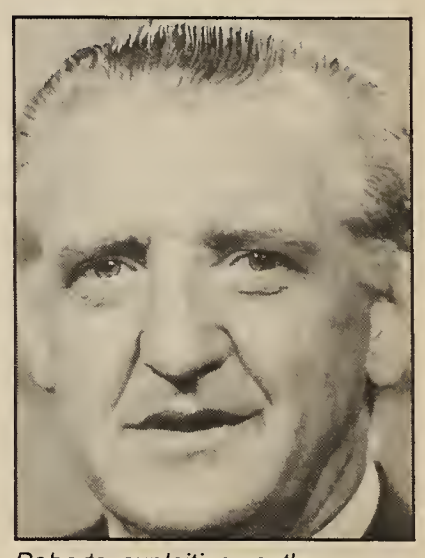
"We have increased the number of specialist, customs investigative staff. We have insured better policing. We have supported new laws so that those who conduct traffic in hard drugs can be sentenced to a maximum of life imprisonment.

"We are committed to new laws to deprive drug traffickers of the profits of their crimes, and we are making sure that all with a part to play operate locally and nationally to tackle the problem decisively."

Mr Roberts said government grants, totalling £160,000 (Cdn $309,360) will be given to each education authority in Wales for classroom campaigns to highlight the potential dangers of teenage alcohol and other drug use.

Each school board will be given funds to appoint a full-time specialist on drug abuse.

Another £200,000 has been allocated for a bilingual (Welsh and English) health education campaign aimed at youth. And, a further £220,000 will be used for treatment and rehabilitation.



Roberts: exploiting youth

INSIDE OUT

Triumphs even the angels didn't see

This is the first in what we hope will be an evolving series of explorations — from the inside out — of the human sides of addiction. The author, a Canadian journalist, hopes to establish "beachheads of awareness" behind the lines of data which so often fail to reflect the pain and the joy — for all of us — of becoming, of being, or of staying whole.

— The Editor

I think I remember — it seems like more than a decade ago — the queasy feeling of spinning and falling, as if I were a mud-splattered boy twirling feverishly to try to become dizzier than anybody in the playground.

I recall the unreal lighting in the room and a mindless urge I had suddenly to smirk broadly at the impossibility of what was going on. Then my knees buckled, and I dropped — right into the deep cave.

I can feel that rug now and see the faces surrounding me, up above my head. I tried to raise myself — what day was this? whose house was it? — but the previously trusty knees just weren't there for me any more.

As I was carried away to the ambulance, I remember looking around and seeing two sweet friends studying my state, an endless, loving sadness in their eyes. And then the realization hit me — like a dozen foghorns moaning very loudly through a deep personal haze. I had just had my Last Call. It was November 21, 1984, and there would never be a Miller Time again.

So ended — I pray it is ended — my particular voyage into the entrails of the North American myth of booze and its attendant rituals. To put a twist on what Tolstoy observed so eloquently in another context: all drunks are the same, whether they're happy or not.

I, of course, thought for years I knew how to handle it all. (It's truly amazing how "special" most alcoholics believe themselves to be, how shrewd and quick and perceptive.) As early as my first drink, I believe I gambled on a powerful notion. This is good, very good, it helps, it delights, and, if it kills me in the end, it won't matter that much at all; I will have had a nice, high time of it. There were to be no long-range plans for me. I was going to play it day by day, skip above the surface of things, flee when too much reality intruded, keep the partying going fast. After all, the 20th century seemed to have made impermanence an icon; I'd try to ride that wave, and booze would be my steadiest friend.

I was sure I held some good cards.

I was known as a "quiet" drinker; my disposition seemed to stay the same, year in, year out, party after party, long lunch/dinner after long lunch/dinner. And it was thought — I had told enough people, certainly — that I knew the score, because my father, a brilliant, tortured man, had been a drinker of another species. His patterns were spectacular, awesome. Dimly, even as a boy, when I was compelled to hear him in the next bedroom going through marathon delirium tremens, I thought I would find the resources to know when to stop if a crunch came.

I remembered a couple of years ago going out to Vancouver, trying to find where my father was buried. I'd lost touch with him a long time before. When I found out he'd ended his days the occupant of a pauper's grave, I went out and did what I'd always done when I'd 'accomplished' anything: I got stiff, blind, stupefied. It was what men of my age, of my generation, were supposed to do.

But last year, before the Last Call came, I had turned 40, and on the surface — it is astounding how wide is the web of lies that alcoholics can spin, like all too-devious black widows, whose main victims, finally, are themselves — I was doing quite well. There was money coming in, from an improbable, even laughable source. Friends chuckled at the bizarre bonanza, seemed truly happy for me. They showed no overt envy, and I tried to make as many self-deprecating jokes as I could about it. I had done nothing, nothing at all, I'd tell them, to deserve this; it was merely Monopoly money. Also, I thought I was 'in love,' and it was nice and easy. No commitments loomed, I could take her for granted a while longer, she was understanding, a "new woman," independent, liked her privacy. Etcetera, etcetera. My new job was humming along, too.

So, in some ways, I felt like I was a kid again, I told them, back in high school, learning a new curriculum. Yes, there wasn't much to this becoming 40 business; it was yet another fraud. But that too, naturally enough, was another lie. Bury it, I said. Bury it deeply, along with the rest lying inside me like thousands of tiny buttons in a huge, bulging steamer trunk.

I don't remember the hospital. I kept notes the few days I was there, but they're meaningless. I told callers I was doing fine — did they know I was like a shell-shocked soldier? — and I'd be back out on the track again. Sure, I'd stopped drinking, for the moment, but hell, yes, I'd return to the bar, maybe, when I felt better. So the days went by, and I went back to my place, which was yet another in a series of 'homes' I'd had over the years, depressing spaces, empty spots filled by drinking alone and making excuses and lying to myself.

It was while I was there, thinking cockily I'd mend easily, but crying much of the time, taking endless walks along the cold streets, that the home truths began.

There's a period of grief when the beer taps are shut off. Call it a little death, an end to possibilities, a speeding up of the process of mortality that leaves you breathless. It strikes not at your body, primarily, although that is there, always, but at your soul. It demands you leave behind your self-pity, your ingenious methods of blocking the door to truths that wound, your immaturity fostered by a culture that insisted you could always strike out for the forest and get away from the things and people that keep most men sane.

The sudden loneliness was shattering, more devastating than any I'd ever felt. The hopelessness and shame I felt in those first few weeks surrounded me like a Berlin Wall. I was opened up as I'd never been before, and the weeks stretched on like a prison term. I worried I'd turn crazy, out of control, but, still, underlying the demons was that final alcoholic arrogance that had to be torn to pieces if I was going to survive.

I believe I am. But it hasn't much at all to do with my efforts.

Sartre was wrong when he said hell is the others. Dead wrong. I know, now, that it's the opposite, and it's a knowledge that is helping to save me. I saw it blossoming at a clinic I went to for three weeks, a clinic I viewed with an intitial distaste. I still had the wall there, I was rigid before the other wounded, who had more honesty and humility in their bones than I'd ever had even for an afternoon. And they had far more humor, which is the key to making it, I'm convinced. By God, when you're stripped free of most of the delusions it's an awfully funny thing to think about yourself.

And then the going back somewhat into the sunlight, and seeing my friends again, and knowing they cared. . . .

By the end of the program, my soul reeling from shock after shock, all those losing cards I'd built through the decades into a house falling to the ground, their knees buckling, too, as it were, I knew what a price I had had to pay for my North American drinking habit. More importantly, I saw inklings of what it was like to try to be a man without that habit, and I saw reasons to hope that perhaps I could get there, too.

I was starting out again as a refugee, glad to be rid of the baggage that had kept me down, knowing there was still so much left I had to dump, praying for the courage to do so. I cherished triumphs of self-discipline so minor I was sure even the angels didn't see them. But they were mine, at last, something that was really mine, and so I've started to go down a long road, ready for a love I will deserve, ready to say yes to situations I've avoided for years, and ready to laugh more than I ever did before.

Ready to try to be merely a man, trying to stay away from Miller Time, looking for a different forest to walk into.

Skol!

The Journal

Published by Addiction Research Foundation of Ontario
33 Russell Street, Toronto, Ontario M5S 2S1
Editorial (416) 595-6053. Advertising 595-6113. Subscriptions 595-6056.

A monthly report for professionals on developments, issues, and events of national and international significance in the field of alcohol and other drugs.

Editor... Letters to the Editor...

TJ relevant, says German reader

I would like to take the time to tell you what a fine publication I think **The Journal** is. Even living and working here in Germany, I find a great deal of what you publish timely, relevant, and useful. I recommend you to anyone who asks about quality publications on alcohol.

A question arises, however. Could you tell me why you have ignored my requests, last year and this year, to publish information about our International Industrial Alcoholism Symposium in your Coming Events?

The next conference is called the 2nd Annual International Industrial Alcoholism Symposium and will be held May 20 to 22, 1986, in Frankfurt, Germany.

Thank you for your assistance in this matter, and, again, for your excellent publication.

Sara Bilik
President, ALMACA Europe Chapter — Conecta
Mulheim, West Germany

(Ed note: We have included the 1986 Conecta symposium in Coming Events — see page 11. Unfortunately, we have no record of having received the earlier information you sent. We are pleased to have events, such as yours, which are related to the addictions field, to use in our column, space permitting.)

TJ helps studies

I have enjoyed **The Journal** for a number of years now.

The information contained in your publication has been particularly helpful in my studies as a municipal councillor, scout leader, and union activist.

Rudi Derstroff
Nepean, Ont

Editorial Board

New TJ advisers

TORONTO — The Journal is pleased to announce the appointment of three new members to its Editorial Advisory Board. Joining the board are Senator Keith Davey, Hugh Segal, and Jan Skirrow.

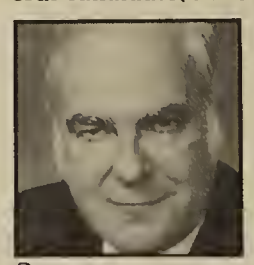
Senator Davey, a former broadcaster and Liberal Party National Organizer was appointed to the Senate of Canada in 1966. He proposed and chaired the Special Senate Committee on Mass Media whose comprehensive report is still used as a source book by universities, community colleges, and media, across the country.

Senator Davey established a communications consultancy in 1969 and serves as a director of several Canadian companies, charities, and sports and cultural organizations.

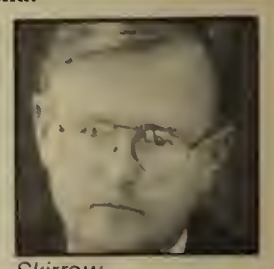
Hugh Segal has been president of Advance Planning Consultants and executive vice-president of Camp Ontario Advertising Associates since 1982. As a former Secretary to the Ontario Policy and Priorities Board and Associate Secretary of Cabinet, and as a former federal candidate, Mr Segal brings to the board a background in provincial and federal politics. He is also a member of the board of directors of several Canadian companies and organizations.

Jan Skirrow, executive director of the Alberta Alcohol and Drug Abuse Commission (AADAC), has been instrumental in developing and implementing a variety of programs in the addictions field in Alberta, including AADAC's adolescent alcohol abuse prevention program and one for repeat impaired driving offenders. Mr Skirrow served as chairman of the 35th International Congress on Alcoholism and Drug Dependence in Calgary last summer and is an honorary vice-president of the International Council on Alcohol and Addictions based in Lausanne, Switzerland.

Retiring from the advisory board is Dr Edward Senay, a former professor of psychiatry, University of Chicago, and executive director, Substance Abuse Services, Inc, Chicago, who has joined an international pharmaceutical company in Switzerland.


Davey


Segal


Skirrow

Changes at The Journal

Books column expanded

TORONTO — With this issue, **The Journal** introduces an expanded New Books column (see page 9). The column will provide more editorial comment on books being reviewed and is aimed particularly at **The Journal** readers, to help them make informed decisions about the potential value to them in their work of the vast, and ever increasing, numbers of publications in this field.

Our new reviewer is Margy Chan, manager of the Addiction Research Foundation's library, the leading library in the world in the addictions field.

Ms Chan will select each month for review the books she considers will be most interesting to the broad cross-section of professionals reading **The Journal**.

Another new feature in New Books will be an occasional guest review by one of our regular readers, who is also an expert in a particular area. This month Donald M Smith, PhD, senior scientific advisor, intergovernmental and international affairs branch, Health and Welfare Canada writes the first one.


Chan


Hauschildt

Ms Chan replaces Ron Hall, a former chief of the ARF library who acted as our reviewer for many years. Ms Chan, a graduate of the University of Hong Kong, also holds a master's degree in library science from the University of Toronto.

Managing editor

TORONTO — Elda Hauschildt has joined the staff of **The Journal** as managing editor.

Ms Hauschildt, a former newspaper reporter, has more than 15 years of experience in both writing and editing, in medical, corporate, and educational fields. She is an honors graduate of Ryerson's journalism course (1967) and has a bachelor's degree (1973), also from Ryerson.

Before joining **The Journal**, Ms Hauschildt worked at The Hospital for Sick Children, Brascan Limited, the Ontario Institute for Studies in Education, and as a freelance writer.

The Journal

Published monthly by Addiction Research Foundation — WHO Collaborating Centre for Research and Training on Alcohol and Drug Dependence Problems

33 Russell St, Toronto, Canada M5S 2S1

PULL OUT

INDEX FOR 1985

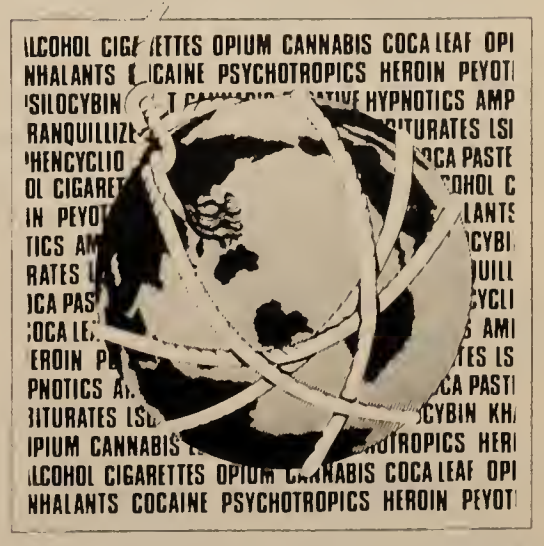
January

February

International Youth Year 1985

March

Soaring drug abuse choking world-wide health effort: WHO



The Journal
INDEX FOR 1985

April

The Children Remembered

— Echoes of parental alcoholism linger on —

May

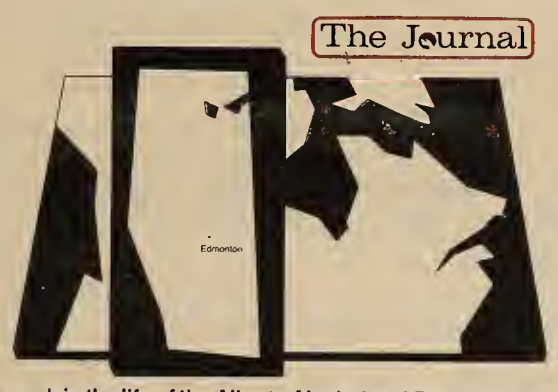
June

The Journal
INDEX FOR 1985

July

August

Alberta Diary



September

October

The Journal
INDEX FOR 1985

The Journal

Women in Nairobi
Backdrop for the future

Increasingly, abuse of alcohol and other drugs is causing concern in The Third World, as it continues to do in developed countries.

However, in the face of immediate and overwhelming problems such as poverty, drought, and starvation, little was said formally about addictions during the United Nations Decade for Women Conference, or the overlapping Non Governmental Organizations (NGO) Forum, held in Nairobi, Kenya this summer

But, individual women — among more than 10,000 at the NGO Forum and 3,000 delegates to the UN Conference — spoke readily of their anxiety about the impact of alcohol and other drug use on youth and family life in their countries

Contributing editor Joan Hollobon completes (The Journal, September) her coverage of the Nairobi meetings

November

December

Earlier campaign was lost in bureaucratic sea

China masses forces to fight tobacco problem

By Thomas Land

GENEVA — China is preparing a vast, nation-wide campaign to persuade its 200-million smokers to quit.

The project has the support here of the United Nations World Health Organization (WHO), which regards smoking as "probably the largest single, preventable cause of ill health" world-wide. The Chinese project follows a WHO call to governments of the hungry belt of the globe to confront a "lung-cancer epidemic" threatening their countries.

WHO statistics show that up to one-third of Chinese males are regular cigarette smokers by the time they are between 16 and 20 years old. Between 1963 and 1975, the overall incidence of lung cancer doubled in Shanghai, China's largest city, where the rate in males is 50.2 per 100,000, higher than in any North American or West European population.

Cigarettes marketed in China contain significantly more tar and nicotine than is permitted in the industrialized countries — the tar yield is in the region of 19 milligrams to 33 mg, compared with 0.5 mg to 20 mg in the West. Yet, at least one Chinese factory has a label advertising its products as "a healthy cigarette."

All that may be changed by the new anti-smoking campaign. It has been heralded by a circular issued jointly by the Chinese Ministry of Public Health and the Central Patriotic Health Campaign Committee.

They seek tough regulations to ban or restrict smoking in all public places, a coordinated mass media drive to inform the public of the dangers of smoking, a manufacturing and marketing code of practice halving the tar content of cigarettes, and the issuing of warning labels identifying health hazards with all packages.

Modern China: with 200-million smokers, one-billion cartons of cigarettes go up in smoke each year

The WHO quotes Chinese public health officials as saying that efforts would be made to produce more 'medicinal' cigarettes and to increase drastically the proportion of filter cigarettes on the market to help cut health risks. Hospitals are to expand services to cure smokers through acupuncture. Doctors as well as teachers are to be asked to act as models by refraining from smoking.

The circular has also called on all government departments to organize their own anti-smoking campaigns and to restrict smoking in hospitals, cinemas, theatres, meeting halls, railway stations, carriages, passenger ships, and classrooms.

The role of public administrators may prove crucial. China launched an unsuccessful anti-smoking campaign in 1979; health officials now blame its failure on lack of coordination by the many relevant government departments. Last year, more than one-billion cartons of cigarettes were sold to satisfy a steeply-rising national demand.

The Chinese hope to reverse that disastrous trend.

A recent authoritative discussion paper published by the WHO concludes: "An epidemic of lung cancer can now be predicted from the rapidly increasing cigarette consumption in many developing countries," including China. And, it said, in the absence of effective national programs against smoking, the epidemic was likely to strike "within a decade."

WHO experts attribute an estimated 590,000 new cases of lung cancer and more than one-million premature deaths a year to cigarette smoking, an increasing proportion of them in the developing regions. Overall, tobacco consumption is slowing down by 1.1% a year in the industrialized world — but it continues to rise by 2.1% a year in developing countries.

Shanghai: ever-present smoke

An Howellian epic on household gods

By Wayne Howell

Where would Homer be without the Trojan Wars? It takes epic events to produce epic poetry. Since we here in Ontario have recently experienced an event equivalent to the fall of Troy (the defeat of the Conservative dynasty that has ruled the province since time immemorial, or the early 1940s, whichever came first), is it not appropriate that an erstwhile bard should celebrate the fall of Tory titans in heroic verse?

But, where to start? With the separate school issue? Perhaps — but even a Virgil or a Milton would have trouble providing a poetic exegesis of that thorny topic. So, the prudent bard turns to the one other subject that captured the imagination of Ontario voters — the Liberal heresy of beer and wine in corner grocery stores.

Epic poems, of course, go on for pages and pages. In the best of them, even the prologues go on for pages and pages. My epic, modestly titled *Paradise Lost, Paradise Regained — Depending On Your Point of View* is no exception. Unfortunately, there is not much of a market for epic poetry these days: my suggestion that the entire epic appear as a special, 40-page supplement in **The Journal** fell on deaf editorial ears. But, as a compromise, I was allowed to present a small fragment of the prologue in my column:

Paradise Lost, Paradise Regained — Depending On Your Point of View

The Prologue (Part I)

Apollo, son of Zeus, I call on thy handmaidens:
Clio, the muse of History,
Thalia, the muse of Comedy,
Calliope, the muse of epic poetry;
Be with me, aid me, and abet me,
As I invoke Ontario's household gods
To guide and succor me in my epic task;
Be with me as I call on those minor deities
Whose familiar faces light up our temples —
Our television screens and shopping malls;
The deities who have guided us through
The sweet mysteries of Lottery,
Showing us the exquisite pleasure that can be gained
Playing the numbers against impossible odds:
Gordon, Mr Hall, Miss Vicky, and Miss Penelope:
I invoke your hallowed names.

I call on you Mr Hall,
You of the Pan-like licentious visage
Beaming above your corner store counter;
You, whose squeals of wanton pleasure
Tempted the chaste Miss Penclope
Into tickets for a Lottery;
You, whose Dionysian heart flutters with glee
At the prospect of introducing Miss Penelope
To the joys of take-out sherry;
Help me to elucidate the economics
Of this Liberalization of the laws
And how and why your anticipated gain
Is Brewers' Retail's loss.

I call on you Miss Penelope;
You who carry the noble name
Of Odysseus's puritanical wife;
You who, despite your apparent infatuation
With Lottario
And other get-rich-quick schemes
Propounded by the great god Hall,
Are the embodiment of pinch-lipped Protestant Ontario,
The WCTU example for us all;
You whose vote for so long saved us
From the licentiousness of adjacent realms —
Quebec, New York, Michigan, and such-like places
Where the hoofed-god Pan plays the pipes of power
And booze can be had at any hour:
Guide me as I attempt to explain
How Liberal plans shake our very Foundation,
Producing warnings too dire to mention.

I call on you, Gordon,
Who stands to Mr Hall
As Prometheus stood to gods of yore;
You, Gordon, whose classic countenance
Melted the heart of Miss Vicky in a trice;
Help me to elucidate the ways a fearless youth
Can turn opportunity into advantage
With a little 'Promethean pilfering'
Through Mr Hall's back door,
Knowing that wild as Miss Vicky and her sister nymphs might be
For the pagan pleasures of Provincial Lottery,
Underage nymphs and satyrs intent on Bacchanalian sport
Appreciate a bit of purloined beer and vino more.

And I call on you Miss Vicky,
Mysterious lady of the darkened shades
Niece and handmaiden to the great Penelope;
Be my muse in this endeavor
An epic poem that lasts forever;
Help me to explain to others
The significance — in Ontario — of Irish colors;
How the Phaeton-like fall of the Big Blue Machine,
Is rooted in a liquor policy basically Orange
And a school policy perceived to be Green.

(Ed note: The characters Dr Howell has used so picturesquely in his "epic" are familiar to Ontario television viewers as Mr Hall, a crusty but humorous old storekeeper; the virtuous Miss Penelope, his faithful lottery-ticket customer; Gordon, Mr Hall's young and respectful nephew and shop assistant; and, Miss Vicky, Miss Penelope's maidenly niece. There is romance in the air, twixt the young especially.)

NEWS AND COMMENT

Norway's ban on tobacco ads debated in Canada

By Rhonda Birenbaum

OTTAWA — Norway's law banning the advertising of tobacco products should be the model for similar legislation in Canada, the Canadian Lung Association says. But, a law professor here says such a law could be legally unjust.

"The Norwegian legislation could be a template for Canadian legislation," Peter Banks, association president, said. "We have sent a copy of it to (Health Minister) Jake Epp and asked him to review it."

Essentially, Norway's 1973 Act on Restrictive Measures for the Marketing of Tobacco Products prohibits the advertising of all types of tobacco products in all media. It also forbids the use of tobacco products and scenes with people smoking in promotions for other goods or services.

"This is the sort of legislation we need to consider here in Canada," Mr Banks told **The Journal**.

However, Chet Mitchell, assistant law professor at Carleton University here, says a ban on tobacco advertising could be seen as legal injustice.

"Banning only the promotion of certain drugs (in this case tobacco) may amount, pharmacologically, to unequal treatment before the law."

The law dictates that like cases be treated alike, Mr Mitchell said. "A tobacco advertising ban would ignore other psychoactive drugs that are legally equivalent to tobacco, particularly alcohol.

"Tobacco is a health hazard, but that hardly makes it unique. Alcohol and tobacco are not the only legal drugs that create health risks. Caffeine, sleeping pills, laxatives, and other substances can be seriously harmful. A selective ban on tobacco ads would raise justified charges of discrimination."

Besides, he added, the ability of advertising to promote consumption is a point of controversy. And, the ability of a ban on advertising to lead to decreased consumption has not been proven.

A British Columbia study in which a brewery voluntarily ceased advertising for 14 months to test its marketing strategy found no change in the consumption of its product. When Manitoba banned beer advertising in 1974, beer sales increased. In the United States, the per capita consumption of beer, wine, or spirits appears to be unrelated to advertising restrictions.

Instead of a total advertising ban, which Mr Mitchell called "extremist and inflexible," he suggested price regulation through taxation as the "fair" way to minimize tobacco consumption.

"Very high taxes on tobacco products is, to my mind, the key issue in curtailing tobacco consumption," he said. "Altering behavior depends more on practical concerns such as price than it does on intellectual warnings."

Mr Mitchell said the government can use price effectively to indicate disapproval. "Every time a person goes to buy cigarettes or other tobacco products, they can be reminded of the disapproval by the very high prices. People are very sensitive to price."

The effects of price changes on consumption of alcohol have been widely investigated, he said. "When alcohol prices rise, consumption falls. The same is true for tobacco products. In fact, one report suggests the highest per capita tobacco consumption is found on (the Channel Islands), where no tax is levied."

Under Mr Mitchell's plan, tobacco taxes would be levied on a sliding scale according to the degree of harm. Light cigarettes would be less expensive than regular cigarettes, chewing tobacco cheaper than cigarettes, nicotine gum cheapest of all.

Another acronym

MONTREAL — United States psychiatrists have added a new acronym to the addictions field lexicon.

The American Academy of Psychiatrists in Alcoholism and Addictions (AAPAA) has been formed in response to a need within the profession for increased communication and awareness about alcoholism and other addictions, said Richard J. Frances, MD, academy president.

Meetings of the academy will be held simultaneously with annual American Psychiatric Association (APA) conventions.

Teen drug use in New Brunswick prompts differing official opinions

BATHURST, NB — Two different views of drug problems were presented to the New Brunswick Association of Chiefs of Police at a meeting here.

Provincial Opposition Leader (Liberal) Frank McKenna said a provincial, self-report study determined 42% of students in grades seven to 12 have used or are using cannabis; 60% of grade 12 students have used or are using drugs; and, approximately 1,600 students have used or are using amphetamines, PCP (phencyclidine), or LSD.

But, Joseph MacIntyre, executive director of the provincial Alcoholism and Drug Dependency Commission (ADDC), says alcohol is the root problem.

Mr MacIntyre: "The road to chemical dependency problems in our society starts with alcohol." Drug dependency research supports his contention, he adds, that "regardless of a commonly-held belief among many people that we have a drug epidemic on our hands, the epidemic, in my opinion, relates to alcohol."

He says statistics indicate a drop in most drug convictions between 1982 and 1983, although diversion of narcotic and controlled drugs from legitimate medical and scientific channels to the illicit market continues to be a problem.

"LSD convictions were down 30%, cannabis convictions dropped by 22%, and there was a decrease of 42% for PCP convictions." Only cocaine registered a conviction increase, of 6%.

Both men say education is a prime weapon in combatting chemical abuse. Mr McKenna wants improved efforts in the schools, while Mr MacIntyre referred to employee assistance and Safe Grad programs.

Mr McKenna, a lawyer, asserts the study quoted shows a ready availability of LSD and PCP in New Brunswick and an increase in cocaine.

GILBERT

'There is no doubt that athletes have used caffeine to enhance their performance.'

Caffeine, endurance, and weight loss

By Richard Gilbert

Apart from the effect on sleep, the clearest behavioral effect of regular doses of caffeine — one or two average cups of coffee, or about 1.5 milligrams per kilogram caffeine — is an increase in general bodily movement. This has mostly been observed only in animals, although when the right measurements are made, the effect can be noticed in humans too.

Even this clearest of behavioral effects is sometimes not found. Some investigators have observed reductions in general activity when they gave these relatively low doses of caffeine to their experimental animals. Almost all studies have found that animals receiving very high doses of caffeine (greater than about 50 mg per kg) show reduced general activity.

In humans, studies of caffeine's effects on activity have focused on work output and athletic performance. The usual finding is that the caffeine in two or three average cups of coffee prolongs the time for which an individual can perform physically exhausting work. The quality of the physical work is not improved, except where — as in long-distance running, cross-country skiing, and cycling — the quality of the performance depends on endurance.

This effect on performance seems stronger when the work load is constant rather than increasing, and when the work is being done at high altitude rather than at sea level and at normal rather than cold temperatures. Also, caffeine has been shown to shorten the time taken to recover from exhausting work.

In one high-altitude place, Tibet, tea has been used for centuries as an aid to endurance. Dr William Emboden wrote in his 1979 book *Narcotic Plants:*

"Weary horses and mules are given large vessels of tea to increase their capacity to work. Mules are said to be gamboling like colts as a result of their tea rations. . . . The distance between villages is accounted for in terms of the number of cups of tea necessary to sustain the person travelling that route. It has been ascertained that three cups of tea is equal to eight kilometres."

How caffeine might enhance endurance is not understood. From what we know about how muscles work, avoidance of exhaustion must involve a slowing down in the rate at which glycogen — the energy source in muscles — is used up. Caffeine has to allow either more efficient use of glycogen or more use of energy sources external to muscles, such as body fat and blood sugars. Preliminary research in this area suggests that caffeine acts both ways.

A review article by Scott K. Powers and Stephen Dodd in an issue of *Sports Medicine* this year concluded that ". . . convincing evidence indicates that caffeine increases both the work output and endurance in long-term exercise. These data suggest that the benefits are probably due to increased lipolysis and a decreased degradation of muscle glycogen."

Some studies have found little or no significant enhancement of endurance by caffeine. Even a very small improvement, however, could make an important difference in an athletics competition. An improvement by 0.6% in the time taken to run 10,000 metres might not be significant enough to satisfy a scientist, but it would have reduced Alberto Cova's winning time at the 1984 Olympic Games in Los Angeles (actually 27.79 minutes) by enough for him to have broken the record of 27.64 minutes set by Lasse Virin at the 1972 games in Munich.

There is no doubt that athletes have used caffeine to enhance their performance. A 1982 study of 775 Belgian racing cyclists of many ages and levels of performance found that their average regular caffeine use was lower than that of the general population, but that some professional cyclists were probably using excessive amounts of caffeine to help them in their races. The authors of this study suggested that urine levels in excess of 15 micrograms per millilitre should be considered evidence of caffeine doping.

In 1962, caffeine was classified as a 'doping agent' by the International Olympic Committee (IOC). It was removed from the list in 1972, but put back in time for the 1984 games. The IOC considers 'high levels' of caffeine in blood, defined as 15 micrograms per millilitre or more — what could be found if a 70-kg athlete drank five cups of strong coffee, one after the other, an hour or so before an event, to be illegal. This level is equivalent to about 21 micrograms of caffeine per millilitre of urine, because urine concentrations of caffeine are typically 40% higher than blood concentrations.

Where hand steadiness or fine motor coordination is required — rather than simple endurance — caffeine can cause a worsening of performance. For example, consumption of two or three cups of coffee has been found to reduce skill at needle threading and handwriting. Not all studies have found a negative effect of caffeine on this kind of behavior. Some have shown an improvement. The question of whether caffeine has a consistent effect on skilled behavior is still to be answered.

When caffeine does disrupt fine motor coordination, a likely cause is an increase in hand or arm tremor. 'Coffee shakes' have long been noted as a consequence of drinking too much of the beverage. Recent work, using equipment capable of detecting small, often invisible movements, has confirmed that caffeine increases tremor. At lower doses (150 mg), the drug may act only to enhance tremor caused in other ways — by fasting, for example.

Caffeine's effects on energy expenditure may be of interest to people who wish to lose weight. The relevant effects are these:

1. Caffeine's elevation of activity levels of the body could mean that food energy is used up in exercise rather than being stored as fat.
2. If the body is at rest, caffeine still causes the body to use more energy. It appears as increased body temperature. Food energy is used to sustain the raised body temperature rather than being deposited as fat.
3. When taken with a meal, caffeine appears to increase the rate at which the food is converted into usable energy.
4. When taken between meals, caffeine causes fats to be transferred from cellular deposits to the blood stream where, as free fatty acids, they can be used as energy by most of the organs of the body. Caffeine is a frequent ingredient of non-prescription diet aids. These are sometimes known as appetite suppressants, although there is no evidence that caffeine does indeed reduce appetite for food. Regular caffeine administration has been shown to contribute to weight loss in animals, but it is not clear whether, in the long term, caffeine use contributes to weight loss in humans.

(This column is based on parts of Chapters 10 and 11 of Richard Gilbert's book Caffeine, *to be published shortly by Chelsea House (New York) as a volume in* The Encyclopedia of Psychoactive Drugs.*)*

New Books

by MARGY CHAN

This is the first New Books column by reviewer Margy Chan. Ms Chan is manager of the Addiction Research Foundation's (ARF) library, the leading library in the addictions field in the world.

Ms Chan will be offering readers editorial comment on the books she includes.

The Journal *would like to hear from readers on this new approach to New Books. Address your letters to: The Editor,* **The Journal**, *Addiction Research Foundation, 33 Russell Street, Toronto, Canada M5S 2S1.*

The Journal *welcomes books for review in this column. Copies should be sent to: New Books,* **The Journal**, *Addiction Research Foundation, 33 Russell Street, Toronto, Canada M5S 2S1.*

Alcoholism Counselling: A Collection of Quotes and Comments

. . . by Frank Thompson

Ever wonder what to say to an alcoholic? Frank Thompson, based on his knowledge of alcoholic beverages and his years of counselling experience, has put together a collection of practical "one-liners" as well as quotations from the classics and literary writers. The material is divided into two sections. The "contemporary" section is sub-arranged into situations such as "confrontation," "clarification," and "lunch break." The classics section contains many anecdotes and quotations that are entertaining to read. The book will appeal to the public as well as counsellors.

Vantage Press, New York, 1985. 144 p. $11.95. ISBN 0-533-06466-X

End of the Line: Quitting Cocaine

. . . by Kathleen R. O'Connell

Increasing cocaine abuse is a current issue in society. This book is intended to help cocaine users and their families understand the problem. It offers "30 successful strategies" to get off, and stay off, the drug. This is a small, compact, and practical book, written in simple and easy-to-read language.

The author is a licensed clinical psychologist who has done some extensive work in alcohol and other drug counselling. Her experience in dealing with drug users in "Silicon Valley," California, brought some insights into the problems of cocaine use in the electronics industry and other professions. People in the helping professions may also find this book useful in understanding cocaine use and its effects at individual, couple, and family, as well as industrial and professional, levels.

Westminster Press, Philadelphia, 1985. 120p. $7.95. ISBN 0-664-24669-9

Alcohol Policies

. . . by Marcus Grant, editor

Increasing alcohol consumption and alcohol-related problems are issues that must be confronted if society is serious about the World Health Organizations' (WHO) goal of health for all by the year 2000. This book is a reflection of the WHO's emphasis on the development of comprehensive national alcohol policies. The book expresses concern about promotional drives which are increasing alcohol consumption, especially in population groups and countries where alcohol use was not previously widespread. The book maintains both comprehensive national policies and concerted international action in the regulation of the international alcohol trade are urgently required. It concludes that a reasonable balance between economic interests and public health interests must be achieved.

Many contributions in the book have been developed from working papers presented at a meeting on the control of alcohol consumption, organized by the WHO in 1983. What is presented is an integrated approach to the whole question of alcohol policy formulation. It is essential reading for those concerned with alcohol policies.

WHO Regional Publications, Copenhagen, 1985. 153 p. $12.10 (Swiss fr. 19). ISBN 92-890-1109-2

Other books

Faith, Hope and Sobriety — John, Wood Lake Books, Winfield, 1985. Autobiographical account of a struggle with alcoholism, to recovery of sobriety. 144p. Wood Lake Books, Box 700, Winfield, BC V0H 2C0, $9.95. ISBN 0-919599-19-2.

Handbook on Alcoholism for Health Professionals — Beider, Ludwig; O'Hagan, John; and Whiteside, Edwin. William Heinemann Medical Books, London, 1985. Alcohol content of common drinks; alcoholic intoxication; hazardous drinking; complications; diagnosis and assessment; management and rehabilitation; prevention. 102p. Heyden and Son, 247 S 41st St, Philadelphia, PA 19104. $11. ISBN 0-433-24721-5.

Eating Right to Live Sober — Ketcham, Katherine and Mueller, L. Ann. Madrona Publishers, Seattle, 1983. "A comprehensive guide to alcoholism and nutrition." 372p. Madrona Publishers, PO Box 22667, Seattle, WA 98122. $9.95. ISBN 0-88089-006-1.

Guest Review

By Donald M. Smith, PhD*

The Fix: The Inside Story of the World Drugs Trade

. . . by Brian Freemantle

A good "tour d'horizon" of illicit drug activities around the world, including both trafficking and the supply of and demand for various drugs. Essentially, it is an amplification of the report of the United Nations International Narcotics Control Board, with juicier details, names, and blame attached. As with any published book, the statistics are a little out of date, but do give roughly the general impression of the magnitude of the problem. Technically, information as to illicit production of drugs and how chemicals are used is frequently wrongly reported; as well, any scientifically-trained person is offended by rough estimates reported to two decimal places.

The book reports a number of generally-accepted stories which the reviewer has heard before and whose veracity cannot be checked. The chapter on forfeiture of the assets of drug traffickers rightly points the finger of blame at the banks and tax havens which launder the proceeds of drug trafficking. However, much remains for the "victim" countries to do to make effective their own laws in this respect.

The author, having discredited the British system in the early chapters, in his conclusion, returns to, and indeed, recommends the British system, leaving the reader holding the ambiguity.

Michael Joseph Ltd, London, 1985. 303p. £10.95. ISBN 0-7181-2461-8.

** Dr Smith is senior scientific advisor, intergovernmental and international affairs branch, Health and Welfare, Canada.*

The Journal

Marketing Dept (595-6056)
Editorial Dept (595-6053)
Advertising Dept (595-6113)

Advertising Rates:

a) Regular Line Rates	$1.09 line
b) Standard Units of Insertion	
1 Page (1,120 lines)	$1,000
½ Page (560 lines)	$500
¼ Page (280 lines)	$250

c) Classified Ads $9.28 per column inch minimum 1", sold in ¼" increases

Circulation: 27,318 (Canada, 21,412; USA, 1,907; Foreign, 386; Bulk, 3,613)
Media 2,254

Single Subscription Rates:
Ontario Residents free
Other Canadian Residents: $16 per year
US & Foreign Residents: $24 per year

Bulk Subscription Rates:
Purchase of 5 or more subscriptions mailed to the same address — 20% discount.
Ontario residents billed as other Canadians.

The Journal, 33 Russell St Toronto, Canada M5S 2S1
ISSN0044-6203 Printed in Canada

DEPARTMENT

Projections

The following selected evaluations of audio-visual materials have been made by the Audio-Visual Assessment Group of the Addiction Research Foundation in Ontario. The ratings are based on a six-point scale. Projections are available in both video and 16mm film unless otherwise specified. For further information, contact Margaret Sheppard at (416) 595-6000 ext 7384.

High and Dry

Number: 676.
Subject heading: Drugs and youth, youth and alcohol.
Details: 30 min, video, color.
Synopsis: Laurie is a contestant on the game show "Risk Your Life." She must answer drug-related questions in three categories: risk, high risk, and sudden death. At first it is fun, but as the risks escalate, Laurie becomes so upset she refuses to continue. The second part of this video is a dramatized interview with David about his drinking problem, with re-enactment of his family life and school experiences he believes contributed to his becoming a problem drinker.
General evaluation: Fair to good (3.8). The first half of this video is a clever production and includes good information. The second half, while containing good information, is so different in style it is difficult to attend to the message.
Recommended use: Because of differences in style in the two parts, this video should be divided. The first part would benefit 12 to 14 year olds; the second part could be used with 14 to 18 year olds. A resource person was recommended in both cases.

This publication is indexed in
BIHEP
BIBLIOGRAPHIC INDEX OF HEALTH EDUCATION PERIODICALS

The Great American Smoke Out

Number: 677.
Subject heading: Smoking.
Details: 30 min, video, color.
Synopsis: One day in each year, people in the United States are urged not to smoke. A woman watching the announcement on television balks at the idea, but eventually decides to try. On TV is a spoof on a celebrity cooking show. Guests include an advertiser of cigarettes and a singing group — each member tells about either quitting or never having smoked. The singing group tries, unsuccessfully, to convince the advertiser to quit. However, when his cigarette sets fire to the couch on which they are sitting, he says he will try to break the habit.
General evaluation: Good (4.2). This contemporary, well-produced video could help people decide to quit smoking or not to start. Its light-heartedness was refreshing. General broadcast was recommended.
Recommended use: This video could benefit those eight years and older.

Cocaine Pain

Number: 678.
Subject heading: Cocaine, treatment/rehabilitation.
Details: 32 min, video, color.
Synopsis: Five people are attending Cokenders, a residential treatment centre for cocaine abusers. The treatment is described as humanistic and holistic, treating every part of the person. Each participant tells how the abuse of cocaine ruined his or her life (eg spending a great deal of money; ruining a career; losing friends; not eating for days on end). The physician who runs the program discusses how serious cocaine addiction can be. Six months after this residential treatment week only one participant is drug-free; the others are still struggling to rid themselves of the drug.
General evaluation: Good (4.4). This contemporary video contained good information on the effects of cocaine abuse. The stories of the five people were very credible and had great emotional impact. General broadcast was recommended.
Recommended use: With a resource person to link the participants' stories with facts about cocaine, this video could benefit those 15 years of age and older.

Make Sure it Isn't You

Number: 680.
Subject heading: Impaired driving.
Details: 38 min, color.
Synopsis: Parents whose children were killed and people who have been maimed for life by impaired drivers tell about their experiences and how they feel now. They convey their anger and frustration about the minimal punishment for impaired drivers. A firefighter, a police officer, and a coroner tell what they see at the scene of an accident and how sick it makes them feel. One impaired driver who killed a boy describes his despair.
General evaluation: Very good to excellent (5.5). This film had great emotional impact, although it was judged to be somewhat long. General broadcast was recommended.
Recommended use: This film would be of benefit to general audiences 15 years of age and older. It could be particularly useful for community groups wishing to mobilize against impaired driving.

A Road to Recovery

Number: 681.
Subject heading: Alcohol/alcoholism overview, treatment/rehabilitation, public relations.
Details: 48 min, color.
Synopsis: Douglas Talbot, MD, of the Ridgeview Institute in Atlanta, Georgia, delivers a lecture on his treatment model for drug-dependent health professionals: a 28-day in-patient treatment program, followed by 23 months of out-patient aftercare. The institute teaches life skills and involves the family in all aspects of treatment.
General evaluation: Very poor to poor (1.5). This poorly-produced film was not judged a good teaching aid. It was difficult to read many of the visuals used.
Recommended use: None.

Coming Events

Coming Events is a free service. While all notices are considered, publication cannot be guaranteed. Deadline is eight weeks in advance of publication. Contact: The Journal, Coming Events, 33 Russell St, Toronto, Canada M5S 2S1.

Canada

Scientific Meeting on Public Health and Health Services Research, Present — Future — Dec 3-4, Ottawa, Ontario. Information: Canadian Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, ON K1Z 8N8.

Alcohol and Other Drugs: You and Your Family — Radio course, begins Jan 6, 1986. Information: Open College, 297 Victoria Street, Toronto, Ontario M5B 1W1, or School for Addiction Studies, 8 May St, Toronto, ON M4W 2Y1.

Group Therapy Course — Jan 20-24, 1986, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Ontario Psychiatric Association Annual Meeting — Jan 23-25, 1986, Toronto, Ontario. Information: Ontario Psychiatric Association, 1528A Dundas St W, Toronto, ON M6K 1T5.

Drugs, Drug Abuse, and the School System — Jan 28-29, March 25-26, 1986, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Interventions: What Every Employer Should Know — Jan 29-31, 1986, Toronto, Ontario. Information: Yvonne Johns, Donwood Institute, intervention services, 175 Brentcliffe Rd, Toronto, ON M4G 3Z1.

Canadian Society of Hospital Pharmacists, 17th Annual Professional Practice Conference — Feb 3-5, 1986, Toronto, Ontario. Information: Ingrid Benedict, CSHP, 123 Edward St, Ste 303, Toronto, ON M5G 1E2.

Pharmacology and Drug Abuse Course — Feb 3-6, 1986, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

The Street is No Place for a Kid: Symposium on Street Youth — Feb 10-12, 1986, Toronto, Ontario. Information: 1st Annual Symposium on Street Youth, Covenant House, 70 Gerrard St E, Toronto, ON M5B 1G6.

Ontario Psychological Association Annual Meeting — Feb 13-15, 1986, Toronto, Ontario. Information: Mona Abbott-Kesting, administrative officer, OPA, 1407 Yonge St, Ste 402, Toronto, ON M4T 1Y7.

Health Promotion Workshop —Feb 24-26, 1986, Toronto, Ontario. Information: Doreen Ross, School for Addiction Studies, Addiction Research Foundation, 8 May St, Toronto, ON M4W 2Y1.

Communications and Relationships in Family Health — March 4-5, 1986, St John's, Newfoundland. Information: Family Health Division, Canadian Public Health Association, 1335 Carling Ave, Ste 210, Ottawa, Ontario K1Z 8N8.

National Consultation on Women and Drugs — May 12-15, 1986, Geneva Park, Ontario. Information: K. Madden, health promotion directorate, Health and Welfare Canada, Rm 449, Jeanne Mance Bldg, Tunney's Pasture, Ottawa, ON K1A 1B4.

Youth and Drugs, PRIDE CANADA Conference — May 22-24, 1986, Saskatoon, Saskatchewan. Information: Eloise E. Opheim, PRIDE CANADA, Ste 111, Thorvaldson Bldg, College of Pharmacy, University of Saskatchewan, Saskatoon, SK S7N 0W0.

United States

10th Annual Southeastern Conference of Alcohol and Drug Abuse (SECAD 10) — Dec 4-8, Atlanta, Georgia. Information: Charter Medical Corporation, Addictive Disease Division, 11050 Crabapple Rd, Ste D-120, Roswell, GA 30075.

The Measurement of Alcohol and Drug Use in Individuals — Dec 6, Buffalo, New York. Information: Research Institute on Alcoholism, 1021 Main St, Buffalo, NY 14203.

2nd Annual Institute on Family Violence — Dec 9-13, Anchorage, Alaska. Information: Cheryl Mann or Ken Duff, Center for Alcohol and Addiction Studies, University of Alaska, Anchorage, 3211 Providence Dr, Anchorage, AK 99508.

Cocaine Addiction — Jan 16, 1986, Center City, Minnesota. Information: Hazelden Continuing Education, Box 11, Center City, MN 55012.

Management Symposium/Policy Forum — Quality of Care — Feb 2-5, 1986, West Palm Beach, Florida. Information: Alcohol and Drug Problems Association, 444 North Capitol St, NW, #181, Washington, DC 20001.

California's Social Model of Recovery from Alcoholism — Feb 23-25, 1986, San Diego, California. Information: Program on Alcohol Issues, University of California, San Diego Extension, X-001, La Jolla, CA 92093.

International Congress and Exposition — Alcohol, Accidents, and Injuries — Feb 24-28, 1986, Detroit, Michigan. Information: National Highway Traffic Safety Association, 400 7th St SW, Washington, DC 20591.

American Pharmaceutical Association — March 15-20, 1986, San Francisco, California. Information: American Pharmaceutical Association, 2215 Constitution Ave, NW, Washington, DC 20037.

American Society for Clinical Pharmacology and Therapeutics — March 20-22, 1986, Washington, DC. Information: Elaine Gallasso, executive secretary, 1718 Gallagher Rd, Norristown, Pennsylvania 19401.

SECAD-West — Current Trends in Addiction — April 3-6, 1986, Denver, Colorado. Information: Barbara Turner or Pat Fields, Charter Medical Corporation, Addictive Disease Division, 11050 Crabapple Rd, Ste D-120, Roswell, Georgia 30075.

American Orthopsychiatric Association Annual Meeting — April 7-11, 1986, Chicago, Illinois. Information: Marion Langer, executive director, 19W 44th St, #1616, New York, NY 10036.

American College of Physicians, Annual Meeting — April 10-13, 1986, San Francisco, California. Information: Robert Moser, executive vice-president, 4200 Pine St, Philadelphia, Pennsylvania 19104.

Prevention 86: Designing the Future — April 16-18, 1986, San Francisco, California. Information: Cindy Burke, conference coordinator, 9738 Lincoln Village Dr, Sacramento, CA 95827.

American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD) and the Research Society on Alcoholism (RSA) — Joint Meeting — April 18-22, 1986, San Francisco, California. Information: AMSAODD-RSA Meeting, 12 W 21st St, New York, NY 10010.

American Occupational Therapy Association, Annual Meeting — April 21-25, 1986, Minneapolis, Minnesota. Information: James Garibaldi, executive director, 1383 Piccard Dr, Ste 301, Rockville, Maryland 20850.

3rd National Conference on Alcohol and Drug Abuse Issues in Higher Education — April 27-29, 1986, San Antonio, Texas. Information: Alcohol and Drug Problems Association of North America, 444 North Capitol St NW, #181, Washington, DC 20001.

NECAD 86 — May 4-7, 1986, Newport, Rhode Island. Information: Jane Drury, conference coordinator, Edgehill Newport Foundation, Beacon Hill Rd, Newport, RI 02840.

Abroad

1st World Congress on Drugs and Alcohol — Dec 15-19, Tel Aviv, Israel. Information: Congress Secretariat, Peltours Ltd, congress department, PO Box 394, Tel Aviv 61003, Israel.

The International Conference on Drug and Alcohol Abuse — Jan 15-17, 1986, Freeport, Grand Bahama. Information: R.R. Travel Agency, 3719 E. Frank Phillips Blvd, Bartlesville, Oklahoma 74006.

Paraquat Symposium — Jan 27, 1986, London, England. Information: Dr G. N. Volnas, Poisons Unit, Avonley Rd, London SE14 5ER, England.

15th International Institute on the Prevention and Treatment of Drug Dependence — April 6-11, 1986, Amsterdam/Noordwijkerhout, Netherlands. Information: ICAA, case postale 140, CH-1001, Lausanne, Switzerland.

2nd Annual International Industrial Alcoholism Symposium — May 20-22, 1986, Frankfurt, Germany. Information: Annette Stappert, conference coordinator, Conecta, 12 Stooter St, 4330 Mulheim 13, Germany.

32nd International Institute on the Prevention and Treatment of Alcoholism — June 1-6, 1986, Budapest, Hungary. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001, Lausanne, Switzerland.

3rd Congress of the International Society for Biomedical Research on Alcoholism — June 8-13, 1986, Helsinki, Finland. Information: Ms Sari Salo, 3rd ISBRA Congress, Alko Ltd, PO Box 350, SF00101, Helsinki, Finland.

International Symposium on Health Education in Schools — July 6-10, 1986, Jerusalem, Israel. Information: D. Tamir, International Symposium, PO Box 394, Tel Aviv 61003 Israel.

Kenya: urban stresses and addictions . . .

The Journal's *contributing editor* **Joan Hollobon** *was in Africa this summer to cover the United Nations conferences marking the end of the Decade for Women. While there, Ms Hollobon prepared the following report on addiction problems in Kenya.*

THE BACK PAGE

NAIROBI — Increased alcoholism in Kenya and other African countries is widely attributed to the stress of rapid cultural change.

Large numbers of people are propelled almost overnight from an ordered, rural existence, with built-in controls and the security of a traditional, structured society where roles and tasks are clearly defined, into an individual, impersonal, Westernized lifestyle.

The well-tailored, educated, articulate executive in the Kenyan branch of a multinational corporation in Nairobi most likely was born in a tribal village.

"Almost the entire present generation of Kenyan elite were born and raised in the rural environment. Most of them, therefore, experienced sudden change from rural to urban lifestyles after independence (in 1963)," writes Wanjiku Kironyo in a booklet, *"Stress in Modern Motherhood and Coping Mechanisms."*

Kenya has almost doubled its population in 16 years — from 10.6 million people in 1969 to an estimated 19 million people now.

Adding to stress among the elite is the heavy burden of responsibility carried by such a small group of highly-educated men and women, without the backup of a large, broadly-educated middle class, in taking over executive jobs in government, business, and the professions formerly held by "expatriates." It's easy to pick up habits like the martini lunch along with other customs of corporate life.

Nor do the unskilled escape: the young man propping up a door post in the slums has found that in the city, his village skills fit him for nothing but unemployment or a monotonous, unsatisfying, laboring job. Alcohol is a cheap escape for the lonely, rootless, and fearful.

The struggle to keep up with change is played out against a backdrop of extreme contrasts.

Medical treatment at Kenyatta National Hospital in Nairobi, for example, contrasts sharply with unmet needs in rural Kenya. There, clean water, proper sanitation, and control of infectious and parasitic diseases are still lacking. People are often plagued by drought, sickness, poverty, and hunger.

The modernization that changed the whole face of Kenyan society in two decades has proceeded far enough to create great inequalities and stresses, but not far enough to provide the support services to help individuals struggling to cope with such forced change. Such services are simply beyond the country's economic capacity.

Ms Kironyo is one of two young psychologists so concerned about the emotional problems they encounter that they set up a private counselling service called Personal Growth Service Centre. The service operates out of a small office in Maendeleo House near the University of Nairobi.

Ms Kironyo and Lillian Kimani are concerned primarily with marital counselling, especially, but not exclusively, with the problems of women. Marital counselling, however, covers an extremely wide area because most of the difficulties arise from some aspect of the change from traditional to modern lifestyles and philosophies.

Ms Kironyo and Ms Kimani both gained experience in counselling alcoholics while studying in the United States: Ms Kironyo in a halfway house for alcohol and other drug addicts in Boston, and Ms Kimani with agencies in San Diego.

The two psychologists told **The Journal** that until recently, alcohol abuse was not seen as a problem, so few studies on drinking patterns in Kenya have been done.

In traditional African society, rights, privileges, duties, and obligations were explicitly defined. Age differences were significant: young people did not join in the activities of older people, at least not until after they married.

This separation extended to drinking: after work older men were allowed to sit down and have beer with friends, but young men were not invited.

Drinking is still predominantly a male activity.

"This is what is happening to the young men today; a man's level of interaction is determined by his economic status. Now, he finds he can drink and the problem is, sometimes he drinks and drinks and drinks . . . there's not much to do after work except drink," Ms Kironyo said.

She says the research she did for her doctoral thesis made it seem "every other family had one member who drank excessively," but whether they were actually "alcoholic" remains to be defined. Often, people sought medical care for illnesses, but rarely was there any follow-up on their drinking.

In the cities, going out to bars several evenings a week is common among rich and poor men alike. In the villages, visiting the beer halls, where local brew is cheap and plentiful, is equally common.

In rural communities, men formerly were expected to take part in discussions or various activities, but the heavy migration of the young and able to towns has left many villages with only the elderly or the unskilled, breaking down the natural groupings.

"Now, the groups are tied in with alcohol. In fact, if you are a Christian you have nowhere to go . . . you become a misfit if you go there and don't smoke or drink," Ms Kironyo said.

Ms Kimani says the present Kenyan lifestyle is very competitive, so that many people "who lack strength and cannot achieve higher . . . suffer greatly, and maybe these are some of the causes of alcoholism."

The modern society makes no provision for counselling — which was always available in an informal way in the traditional society.

A woman might talk over her problems with a senior woman in the tribe as they went together to fetch water. If this was insufficient, other women would be brought in — "it was all very warm and positive. It led to personal development. An individual did not feel singled out or alone or the only one who had such a problem," Ms Kimani explained.

Africans do not open up easily with strangers, so loss of tribal and family support when young people move to the cities "has caused a lot of problems to accumulate in people's lives."

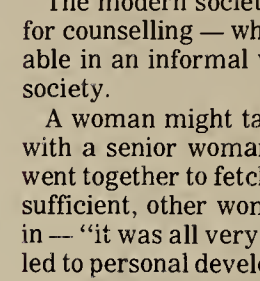
The effect is already being felt on the children, brought up by parents who are under extreme stress and depressed because they feel deprived of the traditional way of life, Ms Kimani said.

Often, the result is drinking, drug abuse, prostitution, wife beating, divorce, and also child abuse, something formerly unheard of.

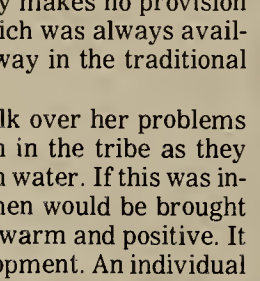
She says that about half of the people who come to their centre for counselling have alcohol problems somewhere in the family.

Business and industry provide no coping mechanisms to help workers adjust. Some companies have dispensaries for physical ailments, but workers with emotional problems are referred to already-overburdened hospitals or doctors. By the time they get treated, individuals frequently have become seriously emotionally ill.

When workers become alcoholic, their employers also suffer through lost time, reduced productivity, and increased accidents on the job.



Kironyo



Kimani

Poster detail

There are no treatment facilities specifically for alcoholism.

Ms Kimani says when she is invited to address company executives on counselling services, there is no problem of acceptance by educated men, but a woman — and a young woman especially — is not easily accepted in such a role by African men remaining in the traditional culture.

She and her colleague run seminars in Nairobi and in rural communities with the support of the local churches.

The Christian churches in Kenya generally see any alcohol consumption as evil, excluding even moderate drinkers from participation in church organizations, Ms Kironyo says.

However, many young people question Christian values now, resenting the church's denigration of traditional African customs and seeing some Christian teachings as "too Westernized," for example, the emphasis on nuclear rather than extended family.

There is a resurgence of interest in the past and in old customs, customs which the generation of Ms Kironyo's parents would not even discuss, regarding them as "primitive" and "backward."

At the same time, there are still many devout people, and the churches are a force in African life.

Out of these conflicting attitudes she hopes eventually a new tradition will be forged combining the best of African and Christian values.

"I believe the African person is at the turning point — he is ready for something, he is not too Westernized, neither too traditional," she said.

. . . as rural ways fade

Samburu women: missing touchstones of family and culture

Women in Kenya have been affected by rapid change in different ways, depending on their age.

Lillian Kimani, in a booklet *The Kenyan Woman*, says older women who remain in the village often suffer severe distress. They have lost touch with their children and feel unable to protect them and others in the extended family who have moved to the city to a life village women do not understand or share.

"The traditional woman tries to protect her 'chicks' — she did so even in the colonial period," Ms Kimani told The Journal. (The 'colonial period' is a phrase often used to refer to the armed upheaval preceding independence, rather than to the entire colonial period.)

Many young men who move to the city now marry outside the tribe, losing touch with their mothers in the villages.

"These ladies are hurting so much," Ms Kimani said.

Cases of emotional breakdown — "very new in our country" among women Wanjiku Kironyo saw in the psychiatric unit in Nairobi — led the psychologist to help start a rural, preventive mental health program.

Different problems face younger women, brought up in traditional extended families with "their own cultural values, taboos, and norms."

The younger women "belong to the first generation in Kenya to undertake two important roles: mother and working woman."

For them, there is no role model and no one to advise — they are pioneers, feeling alienated in the anonymous, competitive city, without the support of extended families.

Among the highly educated, with access to the city's medical care, the well-known "tranquillizer" syndrome is beginning to be seen.

"You see the usual psychosomatic complaints — headaches, aches, and pains. Sometimes this leads to dependency on drugs, often tranquillizers prescribed by a doctor. A lot of these women are drifting innocently into addiction to these drugs," Ms Kimani said.